DOCUMENT RESUME

ED 435 873 CG 029 556

TITLE	Addressing Barriers to Learning: New Directions for Mental Health in Schools. Continuing Education.
INSTITUTION	California Univ., Los Angeles. Center for Mental Health in Schools.
SPONS AGENCY	Health Resources and Services Administration (DHHS/PHS), Washington, DC. Maternal and Child Health Bureau.
PUB DATE	1998-00-00
NOTE	296p.
PUB TYPE	Guides - Classroom - Learner (051)
EDRS PRICE	MF01/PC12 Plus Postage.
DESCRIPTORS	Academic Achievement; Ancillary School Services; *Child Development; *Continuing Education; Elementary Secondary Education; Instructional Materials; *Integrated Services; *Learning; *Mental Health; Needs Assessment; *School Role
IDENTIFIERS	*Psychosocial Development; School Based Services

ABSTRACT

This continuing education module contains three units that describe the role of schools in dealing with psychosocial and mental health problems that interfere with students' learning and performance. The units are: (1) "Placing Mental Health into the Context of Schools and the 21st Century"; (2) "Mental Health Services and Instruction: What a School Can Do"; and (3) "Working with Others to Enhance Programs and Resources." Each unit consists of several sections designed to stand alone. The total set can be taught in straightforward sequence or one or more units can be used in a personalized course. Beginning each section are specific objectives and focusing questions meant to help guide reading and review. Interspersed throughout each section are boxed material designed to help learners think in greater depth about the material. An Instructor's Guide and test questions are provided at the end of each section. A description is provided of accompanying materials that can provide learners with enrichment learning opportunities on key topics as well as with specific resource and technical aids. Contains a glossary of key terms, acronyms, and laws. (Contains 104 references.) (JDM)

Reproductions supplied by EDRS are the best that can be made
from the original document.

Continuing Education

ED 435 873

ADDRESSING BARRIERS TO LEARNING: NEW DIRECTIONS FOR MENTAL HEALTH IN SCHOOLS

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
☒ This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.
• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

Prepared by the School Mental Health Project/Center for Mental Health in Schools, Dept. of Psychology, UCLA, Los Angeles, CA 90095-1563 -- (310) 825-3634. Co-directors: Howard Adelman & Linda Taylor

pport comes in part from the Dept. of Health and Human Services, Public Health Service, Health Resources and Services Administration, Maternal and Child Health Bureau, Office of Adolescent Health.

U.S. Department of Health & Human Services
Public Health Service
HRSA
Health Resources & Services Administration
Maternal & Child Health Bureau
Office of Adolescent Health

CG029556

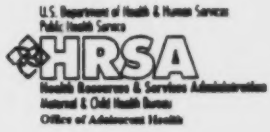
BEST COPY AVAILABLE

Continuing Education

ADDRESSING BARRIERS TO LEARNING: NEW DIRECTIONS FOR MENTAL HEALTH IN SCHOOLS

Prepared by the School Mental Health Project/Center for Mental Health in Schools, Dept. of Psychology, UCLA, Los Angeles, CA 90095-1563 -- (310) 825-3634. Co-directors: Howard Adelman & Linda Taylor

Support comes in part from the Dept. of Health and Human Services, Public Health Service, Health Resources and Services Administration, Maternal and Child Health Bureau, Office of Adolescent Health.



Mental Health in Schools Center
Training and Technical Assistance

Continuing Education

ADDRESSING BARRIERS TO LEARNING: NEW DIRECTIONS FOR MENTAL HEALTH IN SCHOOLS

Units

I. Placing Mental Health into the Context of Schools and the 21st Century

II. Mental Health Services and Instruction: What a School Can Do

III. Working with Others to Enhance Programs and Resources

Prepared by the School Mental Health Project/Center for Mental Health in Schools, Dept. of Psychology, UCLA, Los Angeles, CA 90095-1563 -- (310) 825-3634. Co-directors: Howard Adelman & Linda Taylor

Support comes in part from the Dept. of Health and Human Services, Public Health Service, Health Resources and Services Administration, Maternal and Child Health Bureau, Office of Adolescent Health.

U.S. Department of Health & Human Services
Public Health Service
HRSA
Health Resources & Services Administration
Maternal & Child Health Bureau
Office of Adolescent Health

PREFACE

There is a simple truth that every professional working in schools knows: social, emotional, and physical health deficits and other persistent barriers to learning must be addressed if students are to learn effectively and schools are to accomplish their educational mission. It would be wonderful if the process of addressing such barriers could be handled solely by families or public and private community agencies. Unfortunately, these agencies are unable to do the job alone. Thus, if school reform is to be effective, schools must play a major role in easing problems, increasing opportunities, and enhancing the well-being of students and families.

Recognizing the crisis related to young people's well-being, the U.S. Department of Health and Human Services has launched a variety of initiatives aimed at enhancing the ability of schools to meet the needs of students and their families. One such effort focuses on mental health in schools. As part of this endeavor, two national training and technical assistance centers for mental health in schools were established in 1995 by the Health Resources and Services Administration, Bureau of Maternal and Child Health, Office of Adolescent Health: one center is at UCLA and the other at the University of Maryland at Baltimore.

It is clear that the success of any initiative focused on mental health in schools is dependent on the wide involvement and continuing education of all school personnel. Therefore, one of the major tasks of the UCLA School Mental Health Project's Center for Mental Health in Schools is development of continuing education materials for better mental health interventions in the context of moving toward a comprehensive, integrated approach to addressing barriers to student learning. A comprehensive, integrated approach encompasses (a) prevention and prereferral interventions for mild problems, (b) high visibility programs for high-frequency psychosocial problems, and (c) strategies to assist with severe and pervasive mental health problems. A comprehensive approach recognizes the role school, home, and community life play in creating and correcting young people's problems, especially those who are under-served and hard-to-reach.

We hope that the material contained in this document represents a timely and progressive approach. At the same time, the content, like the field itself, is seen as in a state of continuous evolution. Thus, we are extremely interested in receiving your feedback. Please send your comments to: Howard S. Adelman and Linda Taylor, Co-Directors, Center for Mental Health in Schools, UCLA, Department of Psychology, Los Angeles, CA 90095-1563.

ABOUT COURSE FORMAT

The continuing education module entitled *Addressing Barriers to Learning: New Directions for Mental Health in Schools* consists of an evolving set of modular units focused on *addressing barriers to student learning.* Each unit consists of several sections designed to stand alone. Thus, the total set can be used and taught in a straight forward sequence, or one or more units and sections can be combined into a personalized course. This design also allows learners to approach the material as they would use an internet website (i.e., exploring specific topics of immediate interest and then going over the rest in any order that feels comfortable). The units are packaged in a sequence that reflects the designers' preference for starting with a big picture framework for understanding the context and emerging directions for mental health in schools.

To the Learner

Beginning each section are specific objectives and focusing questions meant to help guide reading and review. Interspersed throughout each section are boxed material designed to help you think in greater depth about the material. Test questions are provided at the end of each section as an additional study aid.

If feasible, establish a study group. Such a group not only can help facilitate the learning of new ideas and skills, it lays a great foundation for ongoing networking, social support, and team building. These, of course, are important ingredients in maintaining morale and minimizing burnout as you deal with difficult problems each day at your school.

***Under separate cover,* you will find a set of *Accompanying Materials* that can provide you with enrichment learning opportunities on key topics as well as with specific resource and technical aids to assist you in applying what you are learning.**

To Curriculum Designers Adopting this Material

The material can be incorporated into various formats:

(1) self-study (individual or group)

(2) participation in workshops (a half or full day continuing education workshop; a sequence of district-wide inservice workshops)

(3) media and computer courses (instructional television -- live, and if feasible, interactive; video or audiotaped courses; computer courses, an internet offering)

(4) a professional journal offering a continuing education series.

Introduction to a Continuing Education Module on
Addressing Barriers to Learning: New Directions for Mental Health In Schools

Schools committed to the success of all children must have an array of activity designed to address barriers to learning. No one is certain of the exact number of students who require assistance in dealing with such barriers. There is consensus, however, that significant barriers are encountered by too many students. Among these barriers are a host of psychosocial and mental health concerns.

Each day school staff are confronted with many students who are doing poorly in school as a result of health and psychosocial problems. Increasingly, personnel at school find it necessary to do something more than their original training prepared them to do. At the same time, education reform and restructuring are changing the whole fabric of schools and calling upon all pupil services personnel to expand their roles and functions.

As a result, school staff need to acquire new ways of thinking about how schools should address barriers to learning and they need additional skills to equip them for emerging new roles and functions. This continuing education module is designed to help meet these needs.

This set of three units focuses on the role of schools in addressing psychosocial and mental health problems that interfere with students' learning and performance.

ADDRESSING BARRIERS TO LEARNING: NEW DIRECTIONS FOR MENTAL HEALTH IN SCHOOLS

Contents of All Three Units

I. Placing Mental Health into the Context of Schools and the 21st Century

A. Introductory Overview

B. The Need to Enhance Healthy Development and Address Barriers to Learning

C. Addressing the Need: Moving Toward a Comprehensive Approach

Coda: A Wide Range of Responses for a Wide Range of Problems

II. Mental Health Services & Instruction: What a School Can Do

A. Screening and Assessment

B. Problem Response and Prevention

C. Consent, Due Process, and Confidentiality

Coda: Networks of Care

Follow-Up Reading

- *ABCs of Assessment*
- *Managing and Preventing School Misbehavior and School Avoidance*

III. Working with Others to Enhance Programs and Resources

A. Working Relationships

B. Working to Enhance Existing Programs

C. Building a Comprehensive, Integrated Approach at Your School

Coda: New Roles for Schools: A Multifaceted Focus

Glossary of Key Terms, Acronyms, and Laws

ACCOMPANYING RESOURCE AND TECHNICAL AIDS

As additional resources for you and others at your school, you will find the following materials under separate cover:

Parent and Home Involvement in Schools

Provides an overview of how home involvement is conceptualized and outlines current models and basic resources. Issues of special interest to under-served families are addressed.

Screening/Assessment: Indicators and Tools

Designed to provide some resources relevant to screening students experiencing problems. In particular, this packet includes a perspective for understanding the screening process and aids for initial problem identification and screening of several major psychosocial problems.

Substance Abuse: Indicators and Screening

Offers some guides to provide schools with basic information on widely abused drugs and indicators of substance abuse. Includes some assessment tools and reference to prevention resources.

School-Based Client Consultation, Referral, and Management of Care

Discusses why it is important to approach student clients as consumers and to think in terms of managing *care*, not *cases*. Outlines processes related to problem identification, triage, assessment and client consultation, referral, and management of care. Provides discussion of prereferral intervention and referral as a multifaceted intervention. Clarifies the nature of ongoing management of care and the necessity of establishing mechanisms to enhance systems of care. Examples of tools to aid in all these processes are included.

Responding to Crisis in Schools

Provides a set of guides and handouts for use in crisis planning and as aids for training staff to respond effectively. Contains materials to guide the organization and initial training of a school-based crisis team, as well as materials for use in ongoing training and as information handouts for staff and in some cases for students and parents.

Where to Get Resource Materials

Offers school staff and parents a listing of centers, organizations, groups, and publishers that provide resource materials such as publications, brochures, fact sheets, audiovisual & multimedia tools on different mental health problems and issues in school settings.

Students and Psychotropic Medication: The School's Role

Underscores the need to work with prescribers in ways that safeguard the student and the school. Contains aids related to safeguards and for providing the student, family, and staff with appropriate information on the effects and monitoring of various psychopharmacological drugs used to treat child and adolescent psycho-behavioral problems.

ADDRESSING BARRIERS TO LEARNING: NEW DIRECTIONS FOR MENTAL HEALTH IN SCHOOLS

Unit I:

Placing Mental Health into the Context of Schools and the 21st Century

Sections

A. Introductory Overview

B. The Need to Enhance Healthy Development and Address Barriers to Learning

C. Addressing the Need: Moving Toward a Comprehensive Approach

Do not follow where the path may lead. Go, instead, where there is no path and leave a trail.

Anonymous

This unit is one of a set of three focused on the school's role in addressing psychosocial and mental health problems that interfere with students' learning and performance.

Schools of the 21st century will call upon us all to play new and expanding roles. Today's schools have both the opportunity and the responsibility to lead the way into the new century. To do so, they must become major participants in movements to reform and restructure schools, and they must help shape initiatives that are attempting to link community resources to schools.

Working closely with others who are concerned with psychosocial problems and healthy development, schools can broaden reform and restructuring in ways that truly address the barriers to student learning and enhance healthy development. In the process, they will continue to redefine their roles and functions and expand the ways in which schools contribute to the well-being of young people and the society.

ADDRESSING BARRIERS TO LEARNING: NEW DIRECTIONS FOR MENTAL HEALTH IN SCHOOLS

Contents of All Three Units

I. Placing Mental Health into the Context of Schools and the 21st Century

A. Introductory Overview

State of the Art
Emerging Trends
New Roles

B. The Need to Enhance Healthy Development and Address Barriers to Learning

Promoting Healthy Development
Personal and Systemic Barriers to Student Learning
Family Needs for Social and Emotional Support
Staff Needs for Social and Emotional Support

C. Addressing the Need: Moving Toward a Comprehensive Approach

Meeting Mandates: Necessary . . . but Insufficient and Often Unsatisfying
Understanding What Causes Different Types of Problems
Clinical Approaches at School Sites
School-Based Health Centers, Family Service Centers, and Full Service Schools
Programmatic Approaches: Going Beyond Clinical Interventions to Address the Full Range of Problems
Needed: A Full Continuum of Programs and Services

Coda: A Wide Range of Responses for a Wide Range of Problems

II. Mental Health Services & Instruction: What a School Can Do

A. Screening and Assessment
B. Problem Response and Prevention
C. Consent, Due Process, and Confidentiality
Coda: Networks of Care
Follow-Up Reading
•*ABCs of Assessment*
•*Managing and Preventing School Misbehavior and School Avoidance*

III. Working with Others to Enhance Programs and Resources

A. Working Relationships
B. Working to Enhance Existing Programs
C. Building a Comprehensive, Integrated Approach at Your School
Coda: New Roles for Schools: A Multifaceted Focus

Glossary of Key Terms, Acronyms, and Laws

Section A: Introductory Overview

Once upon a time, the animals decided that their lives and their society would be improved by establishing a school. The basics identified as necessary for survival in the animal world were swimming, running, climbing, jumping, and flying. Instructors were hired to teach these activities, and it was agreed that all the animals would take all the courses. this worked out well for the administrators, but it caused some problems for the students.

> The squirrel, for example, was an "A" student in running, jumping, and climbing but had trouble in the flying class -- not because of an inability to fly, for she could sail from the top of one tree to another with ease, but because the flying curriculum called for taking off from the ground. The squirrel was drilled in ground-to-air take-offs until she was exhausted and developed charley horses from overexertion. This caused her to perform poorly in her other classes, and her grades dropped to "D"s.

The duck was outstanding in swimming classes -- even better than the teacher. But she did so poorly in running that she was transferred to a remedial class. There she practiced running until her webbed feet were so badly damaged that she was only an average swimmer. But since average was acceptable, nobody saw this as a problem, except the duck.

> In contrast, the rabbit was excellent in running but, being terrified of water, he was an extremely poor swimmer. Despite a lot of makeup work in swimming class, he never could stay afloat. He soon became frustrated and uncooperative and was eventually expelled because of behavior problems.

The eagle naturally enough was a brilliant student in flying class and even did well in running and jumping. he had to be severely disciplined in climbing class, however, because he insisted that his way of getting to the top of the tree was faster and easier.

> It should be noted that the parents of the groundhog pulled him out of school because the administration would not add classes in digging and burrowing. The groundhogs, along with the gophers and badgers, got a prairie dog to start a private school. They all have become strong opponents of school taxes and proponents of voucher systems.

By graduation time, the student with the best grades in the animal school was a compulsive ostrich who could run superbly and also could swim, fly, and climb a little. She, of course, was made class valedictorian and received scholarship offers from all the best universities.

(George H. Reeves is credited with bringing this parable to America.)

Contents:

State of the Art
Emerging Trends
New Roles for Schools

Objectives for Section A

After completing this section of the unit, your should be able to:

•identify a wide range of interveners who could play a role in counseling, psychological, and social service activity at a school

•enumerate, with respect to the activities carried out by such interveners, two specific functions related to (a) providing direct services and instruction, (b) coordinating, developing, and providing leadership for programs, services, and systems, (c) enhancing connections with community resources

•identify at least 2 major emerging trends related to health and psychosocial programs in schools

•explain why schools should play a role in addressing mental health and psychosocial concerns and specify three related examples of possible new roles

A Few Focusing Questions

•*Who at a school might help students with psychosocial concerns?*

•*What factors put students "at risk?"*

•*How might a school play a greater role in shaping a school's overall efforts to address barriers to learning and enhance healthy development?*

It is widely recognized that social, emotional, and physical health deficits and other persistent barriers to learning must be addressed if students are to benefit appropriately from their schooling.

Types of interveners who might play primary or secondary roles in counseling, psychological, and social service activity

Instructional professionals
(e.g., regular classroom teachers, special education staff, health educators, classroom resource staff and consultants)

Health office professionals
(e.g., nurses, physicians, health educators, consultants)

Counseling, psychological, and social work professionals
(e.g., counselors, health educators, psychologists, psychiatrists, psychiatric nurses, social workers, consultants)

Itinerant therapists
(e.g., art, dance, music, occupational, physical, speech-language-hearing, and recreation therapists; psychodramatists)

Personnel-in-training for the above roles

Others
- Aides
- Classified staff (e.g., clerical and cafeteria staff, custodians, bus drivers)
- Paraprofessionals
- Peers (e.g., peer/cross-age counselors and tutors, mutual support and self-help groups)
- Recreation personnel
- Volunteers (professional/paraprofessional/ nonprofessional)

Many professionals struggle to

- ease problems
- increase opportunities
- enhance the well-being of students, families, and school staff.

This box outlines an array of interveners involved in schools who are concerned with mental health and psychosocial matters.

While all students can benefit from interventions to enhance social and emotional development, such activity is essential for those manifesting severe and pervasive problems.

BEST COPY AVAILABLE

Some of the many important functions such personnel can carry out are listed below.

Types of functions provided

Direct services and instruction
(based on prevailing standards of practice and informed by research)
- Identifying and processing students in need of assistance (e.g., initial screening, gatekeeping and triage, client consultation, referral, initial monitoring of care)
- Indepth assessment (individuals, groups, classroom, school, and home environments)
- Crisis intervention and emergency assistance (e.g., psychological first-aid and follow-up; suicide prevention; emergency services, such as food, clothing, transportation)
- Primary prevention through protection, mediation, promoting and fostering opportunities, positive development, and wellness (e.g., guidance counseling; contributing to development and implementation of health and violence reduction curricula; placement assistance; advocacy; liaison between school and home; gang, delinquency, and safe-school programs; conflict resolution)
- Transition and follow-up (e.g., orientations, social support for newcomers, follow-thru)
- Treatment/therapy/counseling, remediation, rehabilitation (incl. secondary prevention)
- Increasing the amount of direct service impact through ongoing management of care multidisciplinary teamwork, consultation, training, and supervision

Coordination, development, and leadership for programs, services, resources, systems
- Needs assessment
- Coordinating activities (e.g., participating on resource coordinating teams to enhance coordination across disciplines and components; with regular, special, and compensatory educ.; in and out of school)
- Mapping and enhancing resources and systems
- Developing new approaches (incl. facilitating systemic changes)
- Monitoring and evaluating intervention for quality improvement, cost-benefit accountability, research
- Advocacy for programs and services and for standards of care in the schools
- Pursuing strategies for public relations and for enhancing financial resources

Enhancing connections with community resources
- Strategies to increase responsiveness to referrals from the school
- Strategies to create formal linkages among programs and services

Few schools, of course, can afford the entire array of personnel and activity outlined. And, because so many young people experience serious problems that interfere with learning and performing in school, most schools indicate that *they need much more* than they have.

The problem of at risk students has grown so great that educators find they must hold special national summits where the emphasis is not only on the academic plight of students, but also on how to make schools safe.

Keith Geiger, President of the National Education Association, reflecting on the association's 1995 "Safe Schools Summit," laments:

> *How does a history teacher explain the relevance of the Emancipation Proclamation to students who feel enslaved by fear? How does a guidance counselor persuade a boy to study hard and aim for college if that boy, in his gut, doesn't expect to live past his 20th birthday?*
>
> *Am I exaggerating? David Satcher, director of the U.S. Centers for Disease Control and Prevention, told the summit about a major new CDC survey of 16,000 students, grades 9 through 12 in both public and private schools.*
>
> *Nearly 22 percent of those surveyed said they had carried a weapon in the previous month. Nearly one quarter (24.1%) of students had seriously considered attempting suicide in the previous 12 months; 8.6 percent had actually attempted suicide in that period. This study follows an earlier CDC finding that violence among young people has reached "epidemic" proportions (p. 14).*

BEST COPY AVAILABLE

- There is growing consensus about the *crisis* nature of the situation. And it is widely recognized that failure to address the problems of children and schools can only exacerbate the health and economic consequences for society.

- *New directions call for functions that go beyond direct service and traditional consultation.* All who work in the schools must be prepared not only to provide direct help but to act as advocates, catalysts, brokers, and facilitators of systemic reform. Particularly needed are efforts to improve intervention efficacy through integrating physical and mental health and social services.

- Ultimately, the need is for *systemic restructuring* of all support programs and services *into a comprehensive and cohesive set of programs.*

- Comprehensive approaches recognize the role school, home, and community life play in creating and correcting young people's problems. From such a perspective, schools must provide *interventions that address individual problems and system changes*. In this regard, there is renewed interest in the notion that school-based and linked services increase access to underserved and hard-to-reach populations.

State of the Art

An extensive literature reports positive outcomes for psychosocial interventions available to schools.

While many of the reports are from narrowly focused brief demonstrations, the research is promising. A significant number of appropriately developed and implemented programs demonstrate benefits for schools (e.g., better student functioning and attendance, less teacher frustration) and for society (e.g., reduced costs for welfare, unemployment, and use of emergency and adult services).

Thus, the literature is encouraging. It provides a menu of "best practices."

And the search for better practices remains a high priority and must be pursued with full consideration of the diverse demographics and conditions that exist in our changing society.

Data on diagnosable mental disorders (based on community samples) suggest that from 12% to 22% of all children suffer from mental, emotional or behavioral disorders, and relatively few receive mental health services. The picture is even bleaker when expanded beyond the limited perspective of *diagnosable* mental disorders to include all young people experiencing psychosocial problems and who Joy Dryfoos defines as "at risk of not maturing into responsible adults." The number "at risk" in many schools serving low-income populations has climbed over the 50% mark. Harold Hodgkinson, director of the Center for Demographic Policy, estimates across the nation 40% of students are in "very bad educational shape" and "at risk of failing to fulfill their physical and mental promise." Because so many live in inner cities and impoverished rural areas and are recently arrived immigrants, he attributes their school problems mainly to conditions they bring with them when they enter kindergarten. These are conditions associated with poverty, difficult and extremely diverse family circumstance, lack of English language skills, violent neighborhoods, physical and emotional problems, and lack of health care. One impact is that at least 12% fail to complete high school, which leads to extensive consequences for them, their families, and society.

Schools are engaged in an increasingly wide array of activity, including promotion of social and emotional development, direct services, outreach to families, and various forms of support for teachers and other school personnel. There is enhanced emphasis on coordination and collaboration within a school and with community agencies to provide the "network of care" necessary to deal with complex problems over time. Thus, services in schools are expanding and changing rapidly. Schools' efforts to address health and psychosocial problems encompass

- prevention and prereferral interventions for mild problems
- high visibility programs for high-frequency problems
- strategies to address severe and pervasive problems.

Emerging Trends

Proliferation of health and psychosocial programs in schools tends to occur with little coordination of planning and implementation. As awareness of deficiencies has increased, major systemic changes have been proposed. Four emerging trends are

- the move *from* narrowly focused *to* comprehensive approaches
- the move *from* fragmentation *to* coordinated/integrated intervention
- the move *from* problem specific and discipline-oriented services *to* less categorical, cross-disciplinary programs
- the move *from* viewing health programs as "supplementary services" *to* policy changes that recognize physical and mental health services as an essential element in enabling learning.

Each trend has implications for what goes on in schools.

Schools have always been called upon to deal with physical health, psychosocial, and mental health concerns. In recent years, these calls have increased.

Moreover, emerging trends require that all school staff continue to expand their roles in advocating and facilitating systemic reforms so that they can be more effective in addressing barriers to student learning and promoting healthy development.

Through an expanded set of roles and functions, such personnel can play a potent role in creating a comprehensive, integrated approach to meeting the needs of the young by helping to weave together what schools can do with what the community offers.

The relatively small number of pupil service personnel available to schools can provide only a limited amount of direct services. Such personnel can have an impact on greater numbers of students if their expertise is used to a greater degree at the level of program organization, development, and maintenance than currently is the case.

Good preservice, interprofessional, and continuing education ensure that a variety of school professionals have specialized understanding of cause (e.g., psychosocial factors and pathology) and intervention (e.g., approaching problem amelioration through attitude and motivation change and system strategies). This knowledge can have many benefits. For instance, mental health perspectives of "best fit" and "least intervention needed" strategies can contribute to reduced referrals and increased efficacy of mainstream and special education programs. With respect to pre and inservice staff development, such perspectives can expand educators' views of how to help students with everyday upsets as well as with crises and other serious problems -- in ways that contribute to positive growth. Specialized mental health understanding also can be translated into programs for targeted problems (e.g., depression, dropout prevention, drug abuse, gang activity, teen pregnancy).

Despite the range of knowledge and skills they bring to a setting, specialists usually are able to see only a small proportion of the many students, families, and school staff who could benefit from their efforts. This is not surprising given the relatively few of these personnel most school districts employ and the many roles they are called on to assume.

This lamentable state of affairs raises several points for discussion. One often discussed idea is that greater dividends (in terms of helping more people) might be forthcoming if such personnel devoted their talents more to prevention. At an even more fundamental level, it seems likely that larger numbers would benefit if they devoted a greater portion of their expertise to creating a comprehensive, integrated approach for addressing barriers to learning and enhancing healthy development. For this to happen, however, there must be a shift in priorities with respect to how they use their time.

Specifically, this involves redeploying time to focus more on functions related to

(a) coordination, development, and leadership (e.g., to evolve and maintain resource integration) and

(b) evolving long-lasting collaborations with community resources.

Given the opportunity, school staff can contribute greatly to creation of a comprehensive, integrated approach.

Concluding Comments

Emerging trends are reshaping the work of specialists in schools. New directions call for going beyond direct service and beyond traditional consultation. All who work in schools must be prepared not only to provide direct help but to act as advocates, catalysts, brokers, and facilitators of systemic reform. Particularly needed are efforts to improve intervention outcomes by integrating physical and mental health and social services. More comprehensively, the need is for systemic reform and restructuring of all education support programs and services to improve the state of the art and provide a safety net of care for generations to come.

This raises many questions. One you may want to think about and discuss at this point is:

How well integrated at my school are the programs to address barriers to learning and enhance healthy development?

The surprised principal, waving the achievement test scores, confronts Ms. Smith, the second grade teacher.
"How did you get these low IQ students to do so well?"
"Low IQ?" she repeats with equal surprise. "What do you mean, low IQ?"
"Well, didn't you see their IQ scores on the list I sent you last fall?"
"Oh no!" Ms. Smith exclaims, "I thought those were their locker numbers!"

A RESOURCE LIST OF RELEVANT REFERENCES

For a fuller discussion of the topic of Mental Health in Schools, see

L. Taylor & H.S. Adelman (1996), Mental health in the schools: Promising directions for practice. *Adolescent Medicine: State of the Art Reviews, 7*, 303-317.

H.S. Adelman (1995), Clinical psychology: Beyond psychopathology and clinical interventions. *Clinical Psychology: Science and Practice, 2*, 28-44.

Other background references

Adelman, H.S. (1966). *Restructuring support services: Toward a comprehensive approach.* Kent, OH: American School Health Association.

Adelman, H.S., & Taylor, L. (in press). System reform to address barriers to learning: Beyond school-linked services and full service schools.. *American Journal of Orthopsychiatry.*

Christopher, G.M., Kurtz, P.D., Howing, P.T. (1989). Status of mental health services for youth in school and community. *Children and Youth Services Review, 11*, 159-174.

Cohen, J.J., & Fish, M.C. (1993). *Handbook of school-based interventions: Resolving student problems and promoting healthy educational environments.* San Francisco: Jossey-Bass.

Costello, E.J. (1989). Developments in child psychiatric epidemiology. *Journal of the American Academy of Child and Adolescent Psychiatry, 28*, 836-841.

Dryfoos, J.G. (1990). *Adolescents at risk: Prevalence and prevention.* London: Oxford Press. .

Dryfoos, J.G. (1994). *Full-service schools: A revolution in health and social services for children, youth, and families.* San Francisco: Jossey-Bass.

Geiger, K. (1995). L.A.'s Kids Courageous. *United Teacher, XXVI,* 14 & 19.

Hoagwood, K. (1995). Issues in Designing and implementing studies of non-mental health care sectors. *Journal of Clinical Child Psychology, 23*, 114-120.

Hodgkinson, H.L. (1993). American education: The good, the bad, and the task. *Phi Delta Kappan, 74*, 619-623.

Igoe, J.B., & Giordano, B.P. (1992). *Expanding school health services to serve families in the 25th century.* Washington, DC: American Nursing Publications.

Kirby, D., Short, L., Collins, J., Rugg, D., Kolbe, L., Howard, M., Miller, B., Sonenstein, F., & Zabin, L.S. (1994). School-based programs to reduce sexual risk behaviors: A review of effectiveness. *Public Health Reports, 109*, 339-360.

Knitzer, J., Steinberg, Z., & Fleisch, B. (1990). *At the schoolhouse door: An examination of programs and policies for children with behavioral and emotional problems*. NY: Bank Street.

Kolbe, L.J. (1993). An essential strategy to improve the health and education of Americans. *Preventive Medicine, 22*, 544-560.

Larson, J. (1994). Violence prevention in the schools: A review of selected programs and procedures. *School Psychology Review, 23*, 151-164.

Lewis, K.S. (1995). *Infants and children with prenatal alcohol and drug exposure: A guide to identification and intervention.* North Branch, MN: Sunrise River Press.

Lewis, K., & Thomson, H. (1987). *Manual of school health.* Addison Wesley, 1987.

Mitchell, A., Seligson, M., & Marx, F. (1989). *Early childhood programs and the public schools: Promise and practice*. Dover, MA: Auburn House.

National Education Goals Panel (1994). *Data for the National Education Goals Report. Volume One: National data.* Washington ,D.C.: U.S. GPO.

National Nursing Coalition for School Health (1995). School health nursing services: Exploring national issues and priorities. *Journal of School Health 65*, 369-389.

Newton, J. (1989). *The new school health handbook: A ready reference for school nurses and educators*. Englewood Cliffs, NJ: Prentice Hall.

Proctor, S.T. (1993). *School nursing practice: Roles and standards*. Scarborough, ME: National Association of School Nurses, Inc.

Schonfeld, D.J. (1996). Talking with elementary school-age children about AIDS and death: Principles and guidelines for school nurses. *Journal of School Nursing, 12*, 26-32.

Schorr, L.B. (1988). *Within our reach: Breaking the cycle of disadvantage*. New York: Doubleday.

Slavin, R., Karweit, N., & Wasik, B. (1994). *Preventing early school failure: Research on effective strategies*. Boston: Allyn & Bacon.

Tyack, D.B., (1992). Health and social services in public schools: Historical perspectives. *The Future of Children, 2*, 19-31.

Test Questions – Unit I: Section A

(1) Which of the following were identified as potential interveners who could play a role could play a role in counseling, psychological, and social service activity at a school?

____(a) counselors
____(b) nurses
____(c) teachers
____(d) aides
____(e) students
____(f) a & b
____(g) a, b, & e
____(h) all the above

(2) With respect to the activities carried out by such interveners, enumerate two specific functions related to

(a) providing direct services and instruction

_____

_____

(b) coordinating, developing, and providing leadership for programs, services, and systems

_____

_____

(c) enhancing connections with community resources

_____

_____

(3) Which of the following is ***not*** an emerging trend related to health and psychosocial programs in schools?

___(a) the move *from* narrowly focused *to* comprehensive approaches

___(b) the move *from* fragmentation *to* coordinated/integrated intervention

___(c) the move *from* problem specific and discipline-oriented services *to* less categorical, cross-disciplinary programs

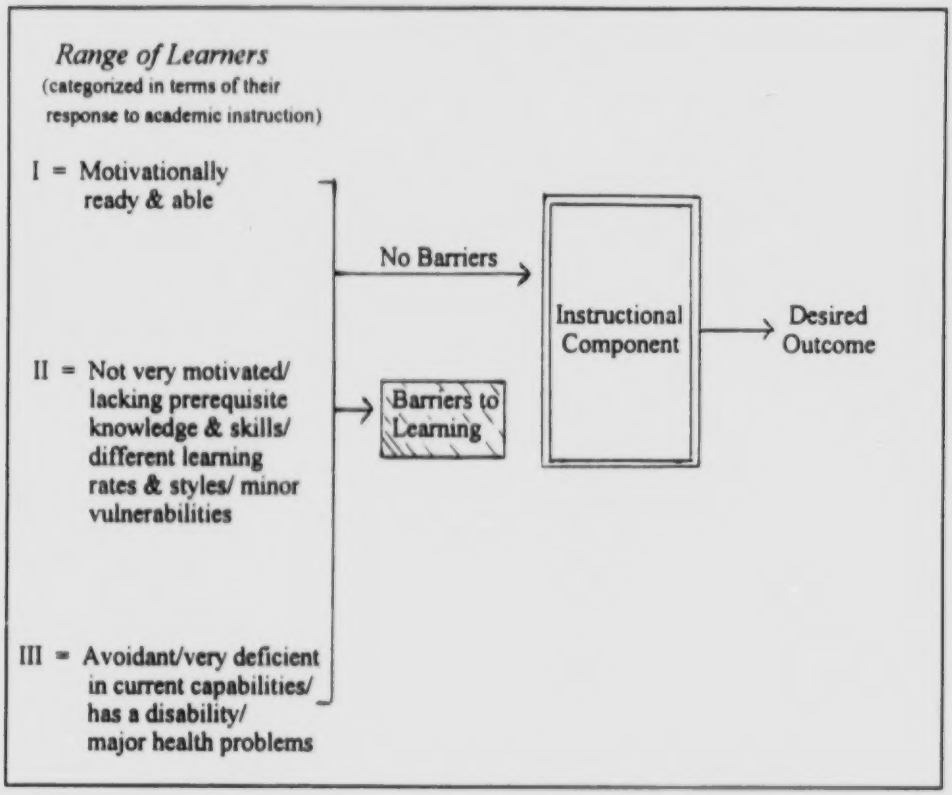
___(d) the move *from* viewing health programs as "supplementary services" *to* policy changes that recognize physical and mental health services as an essential element in enabling learning

___(e) all are emerging trends

(4) Enumerate three possible new roles that schools might play in addressing mental health and psychosocial concerns in schools.

_____
_____
_____

Section B: The Need to Enhance Healthy Development and Address Barriers to Learning


Range of Learners
(categorized in terms of their response to academic instruction)
I = Motivationally ready & able
II = Not very motivated/ lacking prerequisite knowledge & skills/ different learning rates & styles/ minor vulnerabilities
III = Avoidant/very deficient in current capabilities/ has a disability/ major health problems
No Barriers
Barriers to Learning
Instructional Component
Desired Outcome

Contents:

Promoting Healthy Development
Personal and Systemic Barriers to Student Learning
Family Needs for Social and Emotional Support
Staff Needs for Social and Emotional Support

Objectives for Section B

After completing this section of the unit, your should be able to:

- discuss why providing health and social services is an insufficient strategy for addressing barriers to student learning
- identify at least five major areas of focus in enhancing healthy psychosocial development
- differentiate between personal and systemic barriers to student learning and understand the bias toward personal rather than social causation
- understand a range of family needs for social and emotional support and enumerate at least three characteristics of family-oriented interventions

A Few Focusing Questions

- *What are the major barriers that interfere with students learning and performing effectively at school?*
- *How can school staff build alliances with families?*
- *How do persons and environments interact to cause problems*

No one has to make the case that there are many factors interfering with students' learning and performance.

And the consensus is that there are many such barriers to learning in any school enrolling a high proportion of students who are poor or immigrants or both.

School policy makers also understand that poor health can be such a barrier and that healthy development is important to ongoing well-being.

At the same time, school policy makers are clear that health is not a schools primary mission. *Education* is.

Thus, the idea that schools should focus resources on physical and mental health must be advocated within the context of enabling schools to accomplish their primary mission.

The message that must be conveyed is that the mission of educating all students requires a comprehensive set of interventions that address barriers to learning in an integrated way.

STOP. THINK. DISCUSS

What are some major barriers you think must be addressed so that students will learn and perform appropriately at school?

Outlined below are some common barriers usually identified as interfering with learning/ parenting/ teaching. Think about and perhaps discuss with your colleagues which of these you see everyday and what others you would add to the list.

Deficiencies in basic living resources and opportunities for development

- dearth of food in the home
- inadequate clothing
- substandard housing (incl. being homeless)
- lack of transportation
- income at or below the poverty level (e.g., due to unemployment or welfare status)
- lack of after-school supervision for child
- lack of youth recreation and enrichment
- immigration-related concerns (e.g., limited English proficiency, legal status)
- lack of home involvement in schooling
- lack of peer support
- lack of community involvement
- lack of school support services
- lack of social services
- lack of physical, dental, and mental health services

Psychosocial problems

- physical health problems
- school adjustment problems (incl. school avoidance, truancy, pregnancy, and dropouts)
- relationship difficulties (incl. dysfunctional family situations, insensitivity to others, social withdrawal, peers who are negative influences)
- deficiencies in necessary skills (e.g., reading problems, language difficulties, poor coordination, social skill deficits)
- abuse by others (physical and sexual)
- substance abuse
- Overreliance on psychological defense mechanisms (e.g., denial, distortion, projection, displacement)
- eating problems
- delinquency (incl. gang-related problems and community violence)
- psychosocial concerns stemming from sexual activity (e.g., prevention of and reactions to pregnancy or STDs)
- psychopathology/disabilities/disorders

General stressors and underlying psychological problems associated with

- external stressors (objective and perceived) and deficits in support systems
- competence deficits (low self-efficacy/self-esteem, skill deficits)
- threats to self-determination/autonomy/control
- feeling unrelated to others or perceiving threats to valued relationships
- emotional upsets, personality disorders, mood disorders and other psychopathology

Crises and emergencies

- personal/familial (incl. home violence)
- subgroup (e.g., death of a classmate or close colleague)
- school-wide (e.g., earthquake, floods, shooting on campus)

Difficult transitions

- associated with stages of schooling (e.g., entry, leaving)
- associated with stages of life (e.g., puberty, gender identity, job and career concerns)
- associated with changes in life circumstances (e.g., moving, death in the family)

Note: The severity and pervasiveness of all the problems addressed may be mild, moderate, or severe; they also may be narrow or pervasive in terms of how broadly they are manifested.

BEST COPY AVAILABLE

Schools clearly are involved in dealing with barriers to learning.

They hire pupil service professionals and institute services and programs aimed at such concerns as drug abuse, teen pregnancy, dropout prevention, and on and on. In addition, efforts increasingly are made to link with community health and social services.

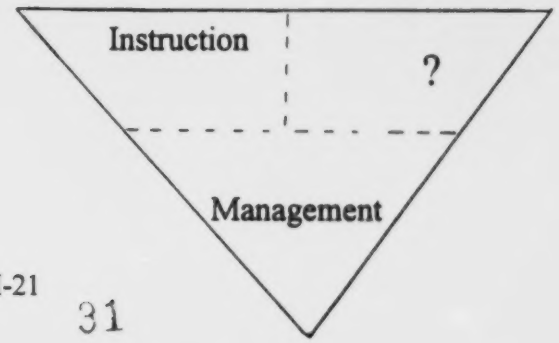
Unfortunately, the prevailing activity is not enough.

Even though poor health and other barriers to student learning are seen as directly related to poor educational outcomes, programs to address barriers to learning are treated as "add-ons." That is, in terms of policy and practice, they are not assigned top priority and often are among the first cut when budgets are tight.

As long as this is the case, many students will continue to encounter barriers that interfere with their benefiting from instructional reforms. And for schools serving large numbers of such students, this means continuation of the pattern of test score averages that do not rise substantially.

This is a central paradox of school reform. That is: school restructuring clearly is intended to enhance student achievement. To this end, reform efforts predominantly focus on improving instruction and school management, with little attention paid to *restructuring and enhancing resources that address barriers to learning*. Consequentially, too many students are unable to take advantage of improved teaching.

What is the solution to this paradox?

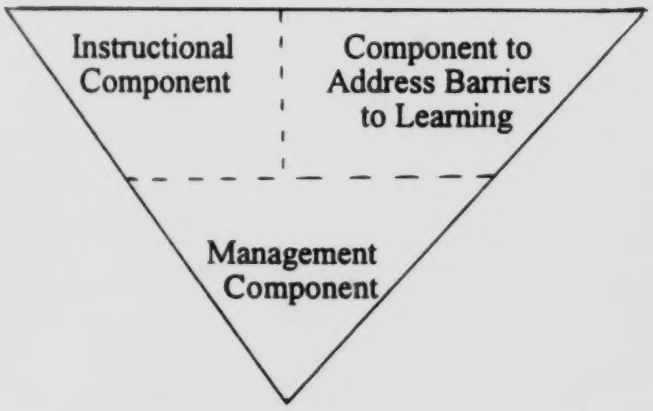


One strategy is to help policy makers understand that current *efforts to restructure schools are missing a major component.*

The missing component doesn't focus on health and social services per se, but it encompasses a strong emphasis on physical and mental health as one major facet of helping schools address barriers to student learning. Such a component is essential in any school committed to the success of *all.*

By themselves, *health and social services* are an insufficient strategy for addressing the biggest problems confronting schools. They are not, for example, designed to address a full range of factors that cause poor academic performance, dropouts, gang violence, teenage pregnancy, substance abuse, racial conflict, and so forth. This is not a criticism of the services per se. The point is that such services are only one facet of a comprehensive approach.

A broad perspective of what is needed emerges by conceiving the missing component for addressing barriers to learning as encompassing efforts to prevent and correct learning, behavior, emotional, and health problems. Such efforts include activity that fosters academic, social, emotional, and physical functioning.



Promoting Healthy Development

Promoting healthy development is one of the keys to preventing mental health and psychosocial problems. For schools, the need is to maintain and enhance health and safety and hopefully do more.

This requires programs that

inoculate through providing positive and negative information, skill instruction, and fostering attitudes (e.g., using facets of health education -- physical and mental -- to build resistance and resilience). Examples of problems addressed with a preventive focus are substance abuse, violence, pregnancy, school dropout, physical and sexual abuse, suicide

directly facilitate development in all areas (physical, social, emotional) and in ways that account for differences in levels of development and current developmental demands. Examples of arenas for activity are parent education and support, day care, preschool, early education, elementary classrooms, recreation and enrichment programs

identify, correct, or at least minimize physical and mental health and psychosocial problems as early after onset as is feasible

Areas of Focus in Enhancing Healthy Psychosocial Development

Responsibility and integrity
(e.g., understanding and valuing of societal expectations and moral courses of action)

Self-esteem
(e.g., feelings of competence, self-determination, and being connected to others)

Social and working relationships
(e.g., social awareness, empathy, respect, communication, interpersonal cooperation and problem solving, critical thinking, judgement, and decision making)

Self-evaluation/self-direction/self-regulation
(e.g., understanding of self and impact on others, development of personal goals, initiative, and functional autonomy)

Temperament
(e.g., emotional stability and responsiveness)

Personal safety and safe behavior
(e.g., understanding and valuing of ways to maintain safety, avoid violence, resist drug abuse, and prevent sexual abuse)

Health maintenance
(e.g., understanding and valuing of ways to maintain physical and mental health)

Effective physical functioning
(e.g., understanding and valuing of how to develop and maintain physical fitness)

Careers and life roles
(e.g., awareness of vocational options, changing nature of sex roles, stress management)

Creativity
(e.g., breaking set)

BEST COPY AVAILABLE

Appreciation of the developmental demands at different age levels is helpful, and awareness of an individual's current levels of development is essential. Basic textbooks provide guides to understanding developmental tasks.

STOP. THINK. DISCUSS

For illustrative purposes, listed below are some major developmental tasks.

What are others you encounter frequently? What do the many developmental tasks suggest for what schools should be doing?

Examples of Major Developmental Tasks

Toddlers (2-4)	Locomotion and increasing control over gross motor skills Early speech Playing with others Beginning of impulse control
Early school age (4-6)	Sex-role identification Increasing control over fine motor skills Acquisition of basic language structure Beginning sense of morality Playing with others in groups
Middle school age (6-12)	Establishing close friendships Strengthening sense of morality Increasing listening skills Ability to use language in multifaceted and complex ways Academic achievement Teamwork Self-evaluation
Early adolescence (12-18)	Accepting one's physique Emotional development Lessening emotional dependence on parents Widening peer relationships Choosing and preparing for higher education/occupation Gender identity, sex role patterns, and sexual relationships Acquiring socially responsible values and behavior patterns

One way to think about all this is to remember that the normal trends are for school-age youngsters to strive toward feeling *competent, self-determining*, and *connected with others*. When youngsters experience the opposite of such feelings, the situation may arouse anxiety, fear, anger, alienation, a sense of losing control, a sense of impotence, hopelessness, powerlessness. In turn, this can lead to externalizing (aggressive, "acting out") or internalizing (withdrawal, self-punishing, delusional) behaviors.

While efforts to facilitate social and emotional development focus on enhancing knowledge, skills, and attitudes, from a mental health perspective the intent is to enhance an individual's feelings of competence, self-determination, and connectedness with others.

Personal and Systemic Barriers to Student Learning

*She's **depressed.***

*That kid's got an **attention deficit hyperactivity disorder**.*

*He's **learning disabled.***

In discussing mental health, it is easy to fall into the trap of thinking only in terms of psychopathology. As the noted anthropologist Ruth Benedict wisely noted:

> ***Normality and exceptionally (or deviance) are not absolutes; both are culturally defined by particular societies at particular times for particular purposes.***

What's in a name?

> Strong images are associated with diagnostic labels, and people act upon these images. Sometimes the images are useful generalizations; sometimes they are harmful stereotypes. Sometimes they guide practitioners toward good ways to help; sometimes they contribute to "blaming the victim" -- making young people the focus of intervention rather than pursuing system deficiencies that are causing the problem in the first place. In all cases, diagnostic labels can profoundly shape a person's future.

Youngsters manifesting emotional upset, misbehavior, and learning problems commonly are assigned psychiatric labels that were created to categorize internal disorders. Thus, there is increasing use of terms such as ADHD, depression, and LD. This happens despite the fact that the problems of most youngsters are not rooted in internal pathology. Indeed, many of their troubling symptoms would not have developed if their environmental circumstances had been appropriately different.

It is not surprising that debates about labeling young people are so heated. Differential diagnosis is difficult and fraught with complex issues (e.g., Adelman, 1995; Adelman & Taylor, 1994; Carnegie Council on Adolescent Development, 1989; Dryfoos, 1990).

The thinking of those who study behavioral, emotional, and learning problems is dominated by models stressing *person* pathology.

Because of this, diagnostic systems do not adequately account for psychosocial problems.

This is well-illustrated by the widely-used *Diagnostic and Statistical Manual of Mental Disorders* -- DSM IV (American Psychiatric Association, 1994).

As a result, *formal* systems for classifying problems in human functioning convey the impression that all behavioral, emotional, or learning problems are due to internal *pathology*.

Thus, most differential diagnoses of children's problems are made by focusing on identifying one or more disorders (e.g., oppositional defiant disorder, attention-deficit/hyperactivity disorder, or adjustment disorders), rather than first asking:

Is there a disorder?

Bias toward labeling problems in terms of *personal* rather than *social causation* is bolstered by factors such as

(a) *attributional bias* --a tendency for observers to perceive others' problems as rooted in stable personal dispositions (Miller & Porter, 1988)

(b) *economic and political influences* -- whereby society's current priorities and other extrinsic forces shape professional practice (Chase, 1977; Hobbs, 1975; Schact, 1985).

There is a substantial community-serving component in policies and procedures for classifying and labeling exceptional children and in the various kinds of institutional arrangements made to take care of them.

"To take care of them" can and should be read with two meanings: to give children help and to exclude them from the community.

Nicholas Hobbs

Overemphasis on pathology skews theory, research, practice, and public policy away from environmentally caused problems and psychosocial problems. There is considerable irony in all this because practitioners understand that most problems in human functioning result from the interplay of person and environment. That is, it is not nature *versus* nurture, but nature transacting with nurture that determines human behavior.

STOP. THINK. DISCUSS

To illustrate, let's look at something school staff encounter everyday -- students who clearly have learning problems and whose misbehavior and various physical complaints seem very much connected to their negative experiences related to academic learning difficulties.

Of the many students who come to the see you with some problem, how many are doing poorly with their classwork? *Do you think some of their physical complaints are relate to their learning problems?*

As you know, not all learning problems stem from the same causes. *How do you understand the range of factors that cause such problems?*

In the classroom, it is evident that some students learn easily, and some do not; some misbehave, some do not. Even a good student may appear distracted on a given day. Everyone who wants to help students who manifest problems needs some basic understanding of

Why the differences?

A common sense answer suggests that each student brings something different to the situation and therefore experiences it differently. And that's a pretty good answer -- as far as it goes. What gets lost in this simple explanation is the reciprocal impact student and situation have on each other -- resulting in continuous change in both.

To clarify the point: a student brings to a situation *capacities and attitudes* accumulated over time, as well as *current states of being and behaving*. These "person" variables transact with each other and also with the environment.

> At the same time, any situation in which students are expected to function not only consists of *instructional processes and content*, but also the *physical and social context* in which instruction takes place. Each part of the environment also transacts with the others.

Obviously, transactions vary considerably and lead to a variety of outcomes. These outcomes may *primarily* reflect the impact of person variables, environmental variables, or both.

> Not all outcomes are desirable. Undesirable outcomes include *deviant, disrupted, and delayed functioning*.

Undesirable outcomes may be due to a dysfunction within the student such a *neurological dysfunction* interfering with effective processing of letters and numbers (a true learning disability) or *psychopathology* that preoccupies the student at the expense of school learning.

> However, as any school nurse will be quick to emphasize, the problem may also reflect any number of *physical health problems*.

It also may be related to a variety of *psychosocial factors* that are barriers to the student attending school regularly or functioning appropriately when at school (frequent school changes because of family mobility, factors related to poverty such as hunger, distractors such as gang affiliation and teen pregnancy, taking drugs, etc.).

> Then, there are the many *environmental stressors* that can negatively affect learning and behavior -- dysfunctional families, physical and sexual abuse, excessive pressure to achieve, etc.

Finally, it is important to remember that in some cases there is nothing objectively wrong with the student or the environment, but for various reasons a student may not mesh well with a given teacher, school, group of peers, and so forth. Common examples of *student-environment mismatches* are seen in the many instances when a fine teacher and an able youngster find they rub each other the wrong way and thus have trouble working together.

Family Needs for Social and Emotional Support

School Counselor:

> *Cara showed up today bruised and battered. We think her dad is abusing her.*

A parent to a teacher:

> *I don't know what to do with Matt. He always seems angry and won't do any school work. I'm so depressed, I can hardly deal with him any more.*

Parent involvement in schools is a prominent item on the education reform agenda. As Epstein (1987) notes, "the evidence is clear that parental encouragement, activities, and interest at home and participation in schools and classrooms affect children's achievements, attitudes, and aspirations, even after student ability and family socioeconomic status are taken into account."

> Home involvement is especially important when students have problems. Clearly, families play a key role in causing and sometimes maintaining a student's problems. They also can play a major role in correcting or at least minimizing problems. And, any family that has a youngster with a problem is likely to pay a price economically, psychologically, and socially.

In all cases, besides whatever direct health and human services the family requires, there may also be a need for social and emotional support.

STOP. THINK. DISCUSS

Think about the families of the students who are referred to you because of problems.

How does the school interact with them? Do they see school staff as allies? If not, why not?

Parents and other caretakers find it difficult to attend to the needs of their children when their own pressing needs are not attended to. This may help account for why parents who are most receptive to efforts to involve them in schools and schooling are a relatively small group.

Parents and others in the home need to feel welcomed and appreciated by the school.

Parents and others in the home often need to have an opportunity to share concerns.

Parents and others in the home need good information when there are problems -- information about the problem and presentation of such information in a context that also recognizes assets.

Parents and others in the home need information and ready access to resources.

In situations where there are large numbers of students who are having problems, the need is for healthy families, healthy schools, and healthy communities.

It seems likely that efforts to involve increasing numbers of parents in improving the well-being of their children must include a focus on improving the well-being of the many parents who are struggling to meet their own basic personal and interpersonal needs.

Thus, schools must be prepared to add programs and services that address such basic needs and staff must reach out to parents with interventions that are welcoming and encourage use of such programs. At the same time, schools must resist the temptation to scold such parents (Adelman, 1994).

Prevailing agendas for parent involvement emphasize meeting societal and school needs. It is not surprising, therefore, that little attention is paid to schools helping parents and caretakers meet their own needs. Schools do offer some activities, such as parent support groups and classes to teach them English as a second language, that may help parents and contribute to their well-being (e.g., by improving parenting or literacy skills). However, the rationale for expending resources on these activities usually is that they enhance parents' ability to play a greater role in improving schooling.

> Another reason for involving parents is to support their efforts to improve the quality of their lives. This includes the notion of the school providing a social setting for parents and, in the process, fostering a psychological sense of community (Sarason, 1996; also see Haynes, Comer, & Hamilton-Lee, 1989).

If a school wants home involvement, it must create a setting where parents, others in the home, school staff, and students want to and are able to interact with each other in mutually beneficial ways that lead to a special feeling of connection. This encompasses finding ways to account for and celebrate cultural and individual diversity in the school community.

> To these ends, ways must be found to minimize transactions that make parents feel incompetent, blamed, or coerced. At the same time, procedures and settings must be designed to foster informal encounters, provide information and learning opportunities, enable social interactions, facilitate access to sources of social support (including linkage to local social services), encourage participation in decision making, and so forth.

Remember:

> *the primary intent is to improve the quality of life for the participants.*

> Although any impact on schooling is a secondary gain, it is encouraging to note that fostering such a climate is consistent with the school reform literature's focus on the importance of a school's climate/ethos/culture.

Barriers to Involving Parents/Home in Schools and Schooling

FORMS OF BARRIERS

TYPES OF BARRIERS	Negative Attitudes	Lack of Mechanisms/ Skills	Practical Deterrents
Institutional	e.g., school administration is hostile toward increasing home involvement	e.g., insufficient staff assigned to planning and implementing ways to enhance home involvement; no more than a token effort to accommodate different languages	e.g., low priority given to home involvement in allocating resources such as space, time, and money
Impersonal	e.g., home involvement suffers from benign neglect	e.g., rapid influx of immigrant families overwhelms school's ability to communicate and provide relevant home involvement activities	e.g., school lacks resources; majority in home have problems related to work schedules, childcare, transportation
Personal	e.g., specific teachers and parents feel home involvement is not worth the effort or feel threatened by such involvement	e.g., specific teachers and parents lack relevant language and interpersonal skills	e.g., specific teachers and parents are too busy or lack resources

BEST COPY AVAILABLE

Approaching the topic from a special education orientation, Dunst et al. (1991) differentiate family-oriented intervention policies and practices as

- family-centered,
- family-focused,
- family-allied, and
- professional-centered.

They categorize the characteristics of family-oriented interventions in terms of those that focus on

(1) enhancing a sense of community (i.e., "promoting the coming together of people around shared values and common needs in ways that create mutually beneficial interdependencies"),

(2) mobilizing resources and supports (i.e., "building support systems that enhance the flow of resources in ways that assist families with parenting responsibilities),

(3) shared responsibility and collaboration (i.e., "sharing ideas and skills by parents and professionals in ways that build and strengthen collaborative arrangements"),

(4) protecting family integrity (i.e., "respecting the family beliefs and values and protecting the family from intrusion upon its beliefs by outsiders"),

(5) strengthening family functioning (i.e., "promoting the capabilities and competencies of families necessary to mobilize resources and perform parenting responsibilities in ways that have empowering consequences"), and

(6) proactive human service practices (i.e., "adoption of consumer-driven human service-delivery models and practices that support and strengthen family functioning").

The case of Jose and his family illustrates many of the complexities involved in working with families.

Jose's family had come to the U.S.A. four years ago. His father worked as a gardener; his mother worked in the garment district. Neither was fluent in English; mother less so than father.

Jose's parents were called to school because of his misbehavior in the classroom. The teacher (who did not speak Spanish) informed them that she was having to use a range of behavioral management strategies to control Jose. However, for the strategies to really work, she said it also was important for the parents to use the same procedures at home. To learn these "parenting skills," the parents both were to attend one of the 6 week evening workshops the school was starting. They were assured the workshop was free, was available in English or Spanish, and there would be child care at the school if they needed it.

After meeting with the teacher, Jose's father, who had reluctantly come to the conference, told his wife she should attend the workshop -- but he would not. She understood that he saw it as her role – not his -- but she was frightened; they fought about it. They had been fighting about a lot of things recently. In the end, she went, but her resentment toward her husband grew with every evening she had to attend the training sessions.

Over the next few months, the mother attempted to apply what she was told to do at the workshop. She withheld privileges and confined Jose to periods of "time out" whenever he didn't toe the line. At the same time, she felt his conduct at home had not been and was not currently that bad -- it was just the same spirited behavior his older brothers had shown at his age. Moreover, she knew he was upset by the increasingly frequent arguments she and her husband were having. She would have liked some help to know what to do about his and her own distress, but she didn't know how to get such help.

Instead of improving the situation, the control strategies seemed to make Jose more upset; he "acted out" more frequently and with escalating force. Soon, his mother found he would not listen to her and would run off when she tried to do what she had been told to do. She complained to her husband. He said it was her fault for pampering Jose. His solution was to beat the youngster.

To make matters worse, the teacher called to say she now felt that Jose should be taken to the doctor to determine whether he was hyperactive and in need of medication. This was too much for Jose's mother. She did not take him to the doctor, and she no longer responded to most calls and letters from the school.

Jose continued to be a problem at school and now at home, and his mother did not know what to do about it or who to turn to for help. When asked, Jose's teacher describes the parents as "hard to reach."

STOP. THINK. DISCUSS

You probably encounter many situations such as that described above. In reflecting on such cases: *What went well? What didn't? What would you do next time?*

The case of Jose and his family raises many issues.

For example, involvement of the home in cases such as Jose's usually is justified by the school as "in the best interests of the student and the others in the class." However, clearly there are different ways to understand the causes of and appropriate responses to Jose's misbehavior.

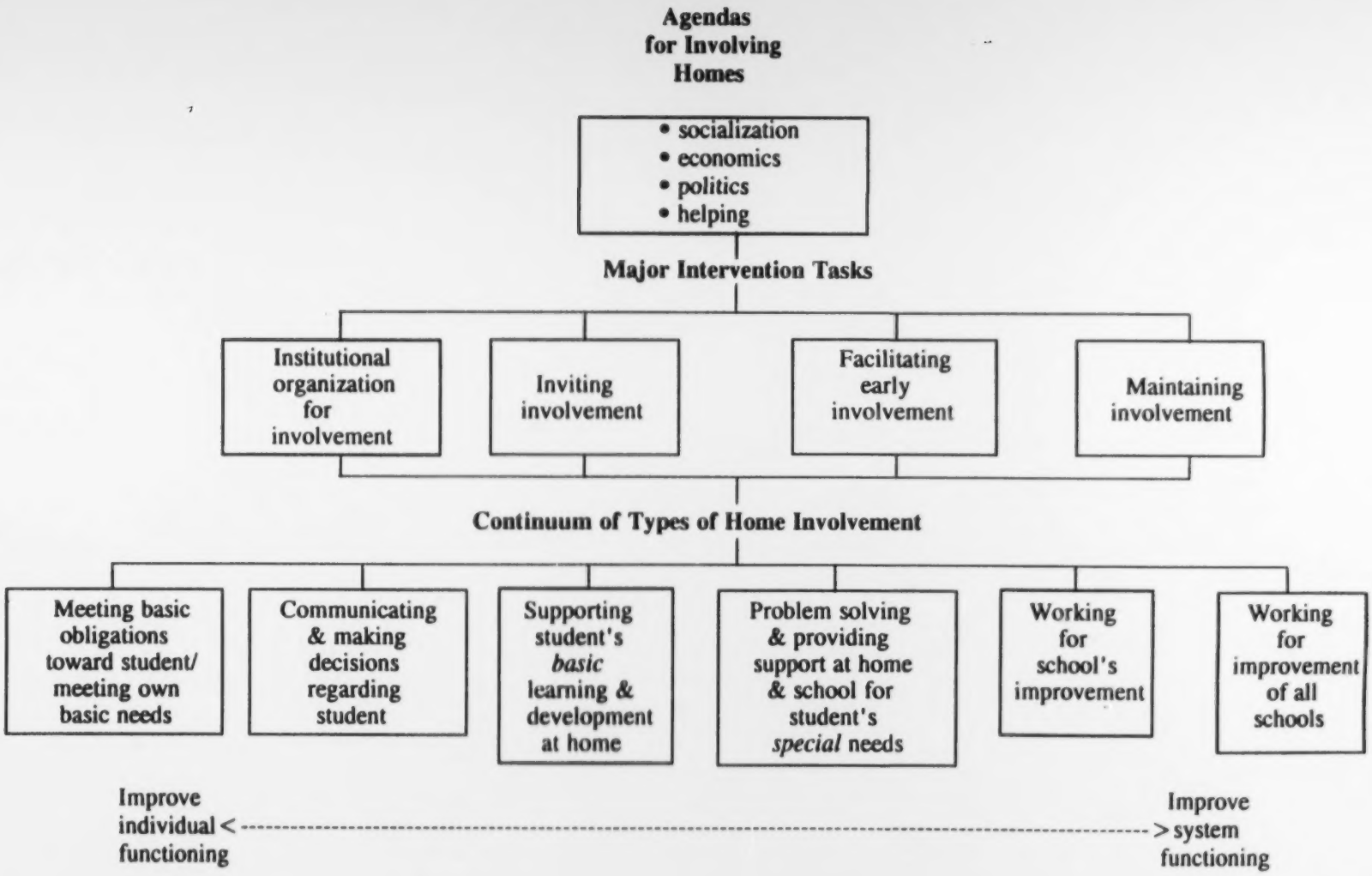
By way of contrast, another analysis might suggest the problem lies in ill-conceived instructional practices and, therefore, might prescribe changing instruction rather than strategies focused on the misbehavior per se.

Even given an evident need for home involvement, the way the mother was directed to parent training raises concerns about whether the processes were coercive.

Questions also arise about social class and race. For example, if the family had come from a middle or higher income background, would the same procedures have been used in discussing the problem, exploring alternative ways to solve it, and involving the mother in parent training? And, there is concern that overemphasis in parent workshops on strategies for controlling children's behavior leads participants such as Jose's mother to pursue practices that often do not address children's needs and may seriously exacerbate problems.

All this reflects the fact that schools have different agendas related to parent involvement, and the different agendas determine the ways they interact with the home.

Note: As a follow-up aid for you and your school, included in the accompanying materials is a copy of an introductory packet entitled *Parent and Home Involvement In Schools* -- prepared by Center for Mental Health in Schools at UCLA.


Agendas for Involving Homes
• socialization
• economics
• politics
• helping
Major Intervention Tasks
Institutional organization for involvement
Inviting involvement
Facilitating early involvement
Maintaining involvement
Continuum of Types of Home Involvement
Meeting basic obligations toward student/ meeting own basic needs
Communicating & making decisions regarding student
Supporting student's *basic* learning & development at home
Problem solving & providing support at home & school for student's *special* needs
Working for school's improvement
Working for improvement of all schools
Improve individual functioning
Improve system functioning

Staff Needs for Social and Emotional Support

No one needs to tell school staff how stressful it is to come to work each day. Stress is the name of the game for all who work in school settings and, unfortunately, some working conditions are terribly stressful.

Some of the stress comes from working with troubled and troubling youngsters. Some is the result of the frustration that arises when everyone works so hard and the results are not good enough. Over time, such stressors can lead to demoralization, exhaustion, and burnout.

The cost of ignoring staff stress is that the programs and services they offer suffer because of less than optimal performance by staff who stay and frequent personnel turnover. As with family members, school staff find it difficult to attend to thee needs of students when their own needs are going unattended.

From this perspective, any discussion of mental health in schools should address ways to help the staff at a school reduce the sources of stress and establish essential social and emotional supports.

Such supports are essential to fostering awareness and validation, improving working conditions, developing effective attitudes and skills for coping, and maintaining balance, perspective, and hope.

Mother to son: *Time to get up and go to school.*

Son: *I don't want to go. It's too hard and the kids don't like me.*

Mother: *But you have to go -- you're the principal.*

REFERENCES

Adelman, H.S. (1994). Intervening to enhance home involvement in schooling. *Intervention in School and Clinic, 29,* 276-287.

Adelman, H.S. (1995). Clinical psychology: Beyond psychopathology and clinical interventions. *Clinical Psychology: Science and Practice, 2,* 28-44.

Adelman, H.S. & Taylor, L. (1994). *On understanding intervention in psychology and education.* Westport, CT: Praeger.

American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders -- DSM IV.* Washington, DC: Author.

Carnegie Council on Adolescent Development's Task Force on Education of Young Adolescents (1989). *Turning Points: Preparing American Youth for the 21st Century.* Washington, DC: Author.

Chase, A. (1977). *The legacy of Malthus: The social costs of the new scientific racism.* New York: Knopf.

Dryfoos, J.G. (1990). *Adolescents at risk: Prevalence and prevention.* London: Oxford University Press.

Dunst, C.J., Trivette, C.M., & Deal, A.G. (1991). *Enabling and empowering families: Principles and guidelines for practice.* Cambridge, MA: Brookline Books.

Haynes, N.M., Comer, J.P., & Hamilton-Lee, M. (1988). The school development program: A model of school improvement. *Journal of Negro Education, 57,* 11-21.

Hobbs, N. (1975). *The future of children: Categories, labels, and their consequences.* San Francisco: Jossey-Bass.

Miller, D.T. & Porter, C.A. (1988). Errors and biases in the attribution process: A reexamination of the fact or fiction question. *Journal of Personality and Social Psychology, 36,* 56-71.

Sarason, S.B. (1996). *Revisiting "the culture of school and the problem of change.* New York: Teachers College Press.

Schact, T.E. (1985). DSM-III and the politics of truth. *American Psychologist, 40,* 513-521.

Test Questions -- Unit I: Section B

(1) Which of the following can be barriers to student learning?

___(a) deficiencies in basic living resources
___(b) psychosocial problems
___(c) underlying psychological problems
___(d) family crises
___(e) transitions such as moving to a new school
___(f) all of the above

(2) Health and social services are designed to address the full range of factors that cause poor academic performance, dropouts, gang violence, teen pregnancy, substance abuse, and so forth.

____True ____False

(3) List five major areas of focus in enhancing healthy psychosocial development.

_____
_____
_____
_____
_____

(4) Current diagnostic systems such as the *Diagnostic and Statistical Manual of Mental Disorders -- DSM IV* do not adequately account for psychosocial problems>

____True ____False

(5) Formal systems for classifying problems in human functioning convey the impression that all behavioral, emotional, or learning problems are due to internal pathology.

____True ____False

(6) Most differential diagnoses of children's problems are made by focusing on identifying one of more internal disorders rather than first asking "Is there a disorder?".

____True ____False

(7) Attributional bias is a tendency for observers to perceive others' problems as rooted in stable personal dispositions.

____True ____False

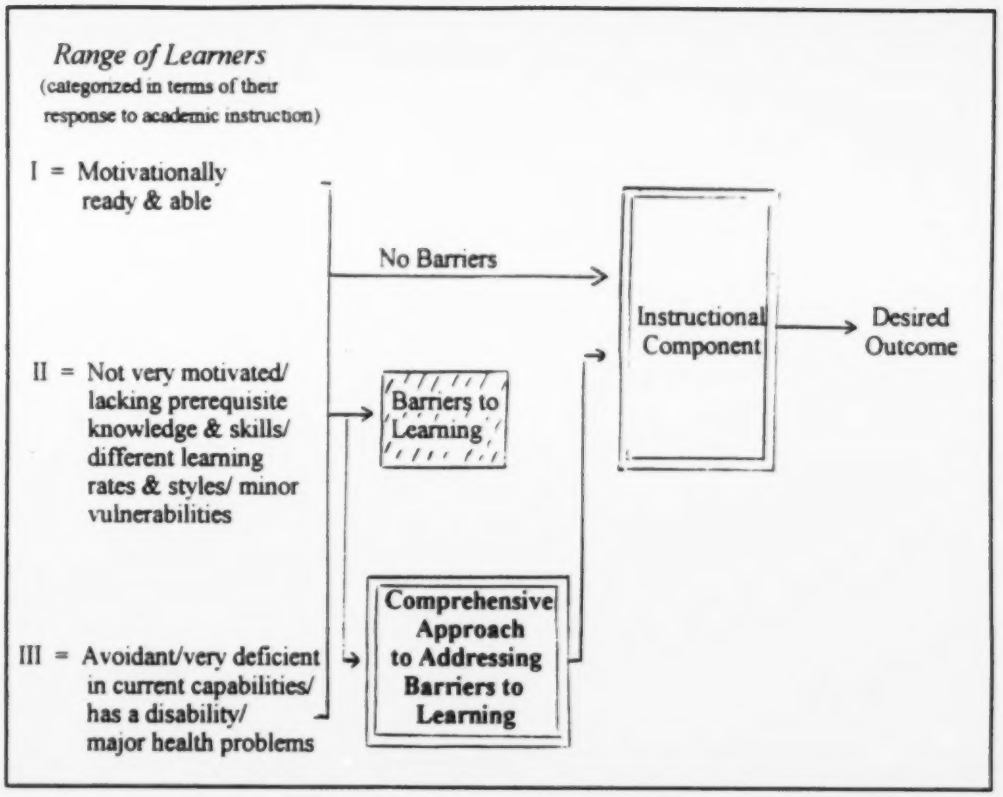
(8) In the mental health field, the tendency is to see most student's problems as arising from environmental/social factors.

____True ____False

(9) List three characteristics of family-oriented interventions.

_____
_____
_____

Section C: Addressing The Need: Moving Toward a Comprehensive Approach


Range of Learners
(categorized in terms of their response to academic instruction)
I = Motivationally ready & able
No Barriers
Instructional Component
Desired Outcome
II = Not very motivated/ lacking prerequisite knowledge & skills/ different learning rates & styles/ minor vulnerabilities
Barriers to Learning
Comprehensive Approach to Addressing Barriers to Learning
III = Avoidant/very deficient in current capabilities/ has a disability/ major health problems

Contents:

Meeting Mandates: Necessary . . .
but Insufficient and Often Unsatisfying
Understanding What Causes Different Types of Problems
Clinical Approaches at School Sites
School-Based Health Centers
Family Service Centers and Full Service Schools
Programmatic Approaches: Going Beyond Clinical Interventions to Address the Full Range of Problems
Needed: A Full Continuum of Programs and Services

Objectives for Section C

After completing this section of the unit, you should be able to:

- state several implications of understanding students' problems in terms of a causal continuum that ranges from internal to external causes
- identify two major reasons why school-based health centers have come to find it necessary to address mental health and psychosocial concerns
- understand the difference between a comprehensive school health program and a comprehensive approach for addressing barriers to learning

A Few Focusing Questions

- How do environments cause individuals to have problems?
- Why is it necessary to go beyond clinical interventions?
- What should a continuum of services and programs consist of in order to adequately address barriers to learning and promote healthy development?

Meeting Mandates: Necessary . . . but Insufficient and Often Unsatisfying

The following are some of the typical tasks assigned to school nurses, psychologists, social workers, counselors, and other specialists:

- appraisal of new enrollees
- physical health, dental, and vision screening as mandated
- assessment of students referred for special education placement
- screening and reporting for suspected child abuse
- screening and referral for suspected substance abuse
- assessment and follow-up to control communicable (including sexually transmitted) diseases
- physical and mental health education
- emergency care when *major* physical or mental health problems arise
- participation in emergency and crisis planning (e.g., planning for how the school should respond to fires, floods, earthquakes, acts of violence and their aftermath)

And of course the ever present "Other tasks as assigned."

> These tasks require use of assessment, counseling, referral, consultation, monitoring, follow-up, information dissemination, and clerical skills related to remedial and preventive health concerns. They involve interactions with students, families, school staff, and professionals in the community.

Anyone seeing a school "support" staff in action as they pursue their many tasks knows they are more than busy.

Anyone who talks with enough school support staff also knows that they are inundated with referrals for students whose problems stem from a variety of physical and mental health concerns.

Many school support staff want to redesign their roles so that much of the clerical and assessment activity related to "mandates" can be streamlined. This would allow them to perform an array of other functions that their training and expertise indicate they are capable of doing. It would allow them to work more intensively with others at a school site to maximize the impact schools have on addressing the most profound barriers causing students to fall by the wayside. And all this has the potential not only to enhance the success of a great many more students, but also should prove more satisfying to the professionals involved.

How can this be done? "Not by working harder, but by working smarter."

One essential element in working smarter is to have an enhanced conceptual base that can increase effectiveness. And one of the essential elements of such a conceptual base is accounting for a full range of factors that cause students to have problems.

Understanding What Causes Different Types of Problems

Before the 1920s, the tendency was to view human behavior as determined primarily by something within the person, especially inborn characteristics. As the psychological school of thought known as *behaviorism* gained in influence, a strong competing view arose. Behavior was seen as shaped by environmental influences, particularly the stimuli and reinforcers one encounters.

Today, human functioning is viewed in *transactional* terms -- as the product of a reciprocal interplay between person and environment. However, prevailing approaches to labeling and addressing human problems still create the impression that problems are determined by *either* person or environment variables.

This is both unfortunate and unnecessary -- unfortunate because such a view limits progress in practice and research, unnecessary because a transactional view encompasses the position that problems may be caused by person, environment, or both. This broad paradigm encourages a comprehensive perspective of cause and correction.

The following is a way to think about the implications of a broad framework for understanding the causes of students' problems.

This way of thinking offers a useful *starting* place for classifying behavioral, emotional, and learning problems and helps avoid overdiagnosing internal pathology.

As illustrated below, such problems can be differentiated along a continuum that separates those caused by internal factors, environmental variables, or a combination of both.

Problems Categorized on a Continuum Using a Transactional View of the Primary Locus of Cause

Problems caused by factors in the environment (E)	Problems caused equally by environment and person	Problems caused by factors in the the person (P)
E (E<--->p)	E<--->P (e<--->P)	P
Type I problems	Type II problems	Type III problems
•caused primarily by environments and systems that are deficient and/or hostile •problems are mild to moderately severe and narrow to moderately pervasive	•caused primarily by a significant *mismatch* between individual differences and vulnerabilities and the nature of that person's environment (not by a person's pathology) •problems are mild to moderately severe and pervasive	•caused primarily by person factors of a pathological nature •problems are moderate to profoundly severe and moderate to broadly pervasive

In this conceptual scheme, the emphasis in each case is on problems that are beyond the early stage of onset.

BEST COPY AVAILABLE

To highlight a few points about the illustration:

- Problems caused by the environment are placed at one end of the continuum and referred to as *Type I problems*.
- At the other end are problems caused primarily by pathology within the person; these are designated as *Type III problems*.
- In the middle are problems stemming from a relatively equal contribution of environmental and person sources, labelled *Type II problems*.

Also note that in this scheme, diagnostic labels denoting *extremely* dysfunctional problems *caused by pathological conditions within a person* are reserved for individuals who fit the Type III category.

> Obviously, some problems caused by pathological conditions within a person are not manifested in severe, pervasive ways, and there are persons without such pathology whose problems do become severe and pervasive. The intent is not to ignore these individuals. As a first categorization step, however, it is essential they not be confused with those seen as having Type III problems.

At the other end of the continuum are individuals with problems arising from factors outside the person (i.e., Type I problems). Many people grow up in impoverished and hostile environmental circumstances. Such conditions should be considered first in hypothesizing what *initially* caused the individual's behavioral, emotional, and learning problems. (After environmental causes are ruled out, hypotheses about internal pathology become more viable.)

To provide a reference point in the middle of the continuum, a Type II category is used. This group consists of persons who do not function well in situations where their individual differences and minor vulnerabilities are poorly accommodated or are responded to hostilely. The problems of an individual in this group are a relatively equal product of person characteristics and failure of the environment to accommodate that individual.

> There are, of course, variations along the continuum that do not precisely fit a category. That is, at each point between the extreme ends, environment-person transactions are the cause, but the degree to which each contributes to the problem varies. Toward the environment end of the continuum, environmental factors play a bigger role (represented as E<--->p). Toward the other end, person variables account for more of the problem (thus e<--->P).

Clearly, a simple continuum cannot do justice to the complexities associated with labeling and differentiating psychopathology and psychosocial problems.

Furthermore, some problems are not easily assessed or do not fall readily into a group due to a lack of information and comorbidity.

> Starting with a broad model of cause, however, helps practitioners counter tendencies to prematurely conclude that a problem is caused by pathology within the individual and thus helps avoid blaming the victim (Ryan, 1971).
>
> It also helps highlight the notion that improving the way the environment accommodates individual differences may be a sufficient intervention strategy.

STOP. THINK. DISCUSS

Think about the last time you had a significant problem related to doing your work. *What caused it? Was it because of something wrong with you? the environment? the interaction between the two?*

Outlined on the next page is an aid for thinking about the many causes of learning, behavior, and emotional problems.

Factors Instigating Emotional, Behavioral, and Learning Problems

Environment (E)

(Type I problem)

1. Insufficient stimuli (e.g.,prolonged periods in impoverished environments; deprivation of learning opportunities at home or school such as lack of play and practice situations and poor instruction; inadequate diet)
2. Excessive stimuli (e.g., overly demanding home, school, or work experiences, such as overwhelming pressure to achieve and contradictory expectations; overcrowding)
3. Intrusive and hostile stimuli (e.g., medical practices, especially at birth, leading to physiological impairment; contaminated environments; conflict in home, school, workplace; faulty child- rearing practices, such as long-standing abuse and rejection; dysfunctional family; migratory family; language used is a second language; social prejudices related to race, sex, age, physical characteristics and behavior)

Person (P)

(Type III problems)

1. Physiological insult (e.g., cerebral trauma, such as accident or stroke, endocrine dysfunctions and chemical imbalances; illness affecting brain or sensory functioning)
2. Genetic anomaly (e.g., genes which limit, slow down, or lead to any atypical development)
3. Cognitive activity and affective states experienced by self as deviant (e.g., lack of knowledge or skills such as basic cognitive strategies; lack of ability to cope effectively with emotions, such as low self-esteem)
4. Physical characteristics shaping contact with environment and/or experienced by self as deviant (e.g., visual, auditory, or motoric deficits; excessive or reduced sensitivity to stimuli; easily fatigued; factors such as race, sex, age, or unusual appearance that produce stereotypical responses)
5. Deviant actions of the individual (e.g., performance problems, such as excessive errors in performing; high or low levels of activity)

*Interactions and Transactions Between E and P**

(Type II problems)

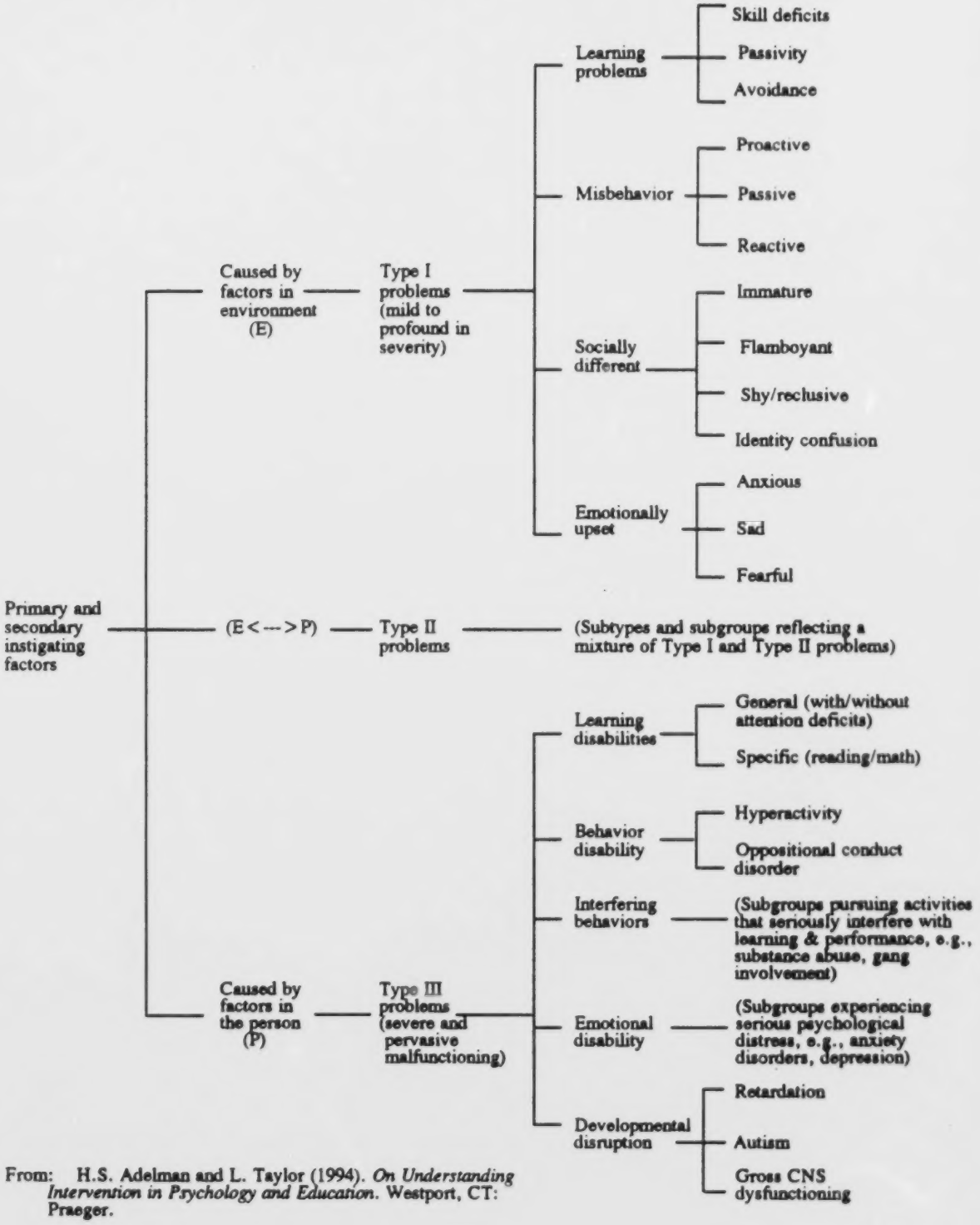
1. Severe to moderate personal vulnerabilities and environmental defects and differences (e.g., person with extremely slow development in a highly demanding environment, all of which simultaneously and equally instigate the problem)
2. Minor personal vulnerabilities not accommodated by the situation (e.g., person with minimal CNS disorders resulting in auditory perceptual disability trying to do auditory-loaded tasks; very active person forced into situations at home, school, or work that do not tolerate this level of activity)
3. Minor environmental defects and differences not accommodated by the individual (e.g., person is in the minority racially or culturally and is not participating in many social activities because he or she thinks others may be unreceptive)

*May involve only one (P) and one (E) variable or may involve multiple combinations.

From: H.S. Adelman and L. Taylor (1993). *Learning problems and learning disabilities: Moving forward*. Pacific Grove, CA: Brooks/Cole. Reprinted with permission.

BEST COPY AVAILABLE

The following diagram uses an understanding of person, environment, and interactional causes to outline and differentiate among the types of problems seen among students.



From: H.S. Adelman and L. Taylor (1994). *On Understanding Intervention in Psychology and Education*. Westport, CT: Praeger.

BEST COPY AVAILABLE

Clinical Approaches at School Sites

All schools have and benefit from counseling, psychological, and social service interventions and want more.

Some of the services are provided by student services professionals hired by the school district.

In addition, a few community services are appearing on campuses as part of the effort to base some of these at school sites.

For many years, clinical approaches in school settings were offered in a practitioner's office and carried out in relative isolation of other interventions aimed at a student and her or his family.

Recently, efforts to increase the range of services at school sites and to coordinate such efforts has led to an expanded number of school-based health centers and family service centers.

School-Based Health Centers

Many of the now over 700 school-based or linked health clinics are described as comprehensive centers (Advocates for Youth, 1994; Dryfoos, 1994; Robert Wood Johnson Foundation, 1993; Schlitt, Rickett, Montgomery, & Lear, 1994). This reflects the fact that the problems students bring to such clinics require much more than medical intervention.

The school-based clinic movement was created in response to concerns about teen pregnancy and a desire to enhance access to physical health care for underserved youth. Soon after opening, most clinics find it essential also to address mental health and psychosocial concerns. The need to do so reflects two basic realities. One, some students' physical complaints are psychogenic, and thus, treatment of various medical problems is aided by psychological intervention. Two, in a large number of cases, students come to clinics primarily for help with no medical problems, such as personal adjustment and peer and family relationship problems, emotional distress, problems related to physical and sexual abuse, and concerns stemming from use of alcohol and other drugs. Indeed, up to 50% of clinic visits are for nonmedical concerns (Adelman, Barker, & Nelson, 1993; Center for Reproductive Health Policy Research, 1989; Robert Wood Johnson Foundation, 1989).

Thus, as these clinics evolve, so does the provision of counseling, psychological, and social services in the schools. At the same time, given the limited number of staff at such clinics, it is not surprising that the demand for psychosocial interventions quickly outstrips the resources available.

Without a massive infusion of money, school-based and linked health clinics can provide only a restricted range of interventions to a limited number of students. Thus, the desire of such clinics to be comprehensive centers in the full sense of the term remains thwarted.

BEST COPY AVAILABLE

Family Service Centers and Full Service Schools

Dryfoos (1994, 1995) encompasses the trend to develop school-based primary health clinics, youth service programs, community schools, and other similar activity under the rubric of *full service schools.* (She credits the term to Florida's comprehensive school-based legislation.)

As she notes in her review:

> Much of the rhetoric in support of the full service schools concept has been presented in the language of *systems change,* calling for radical reform of the way educational, health, and welfare agencies provide services. Consensus has formed around the goals of one stop, seamless service provision, whether in a school- or community-based agency, along with empowerment of the target population. ... most of the programs have moved services from one place to another; for example, a medical unit from a hospital or health department relocates into a school through a contractual agreement, or staff of a community mental health center is reassigned to a school, or a grant to a school creates a coordinator in a center. As the program expands, the center staff work with the school to draw in additional services, fostering more contracts between the schools and community agencies. But few of the school systems or the agencies have changed their governance. The outside agency is not involved in school restructuring or school policy, nor is the school system involved in the governance of the provider agency. The result is not yet a new organizational entity, but the school is an improved institution and on the path to becoming a different kind of institution that is significantly responsive to the needs of the community (p. 169).

Full service schools reflect the desire for comprehensiveness; the reality remains much less than the vision. As long as such efforts are shaped primarily by a school-linked services model (i.e., initiatives to restructure to community health and human services), resources will remain too limited to allow for a comprehensive continuum of programs.

> And in their struggle to find ways to finance programs for troubled and troubling youth, community agencies and schools are forced to tap into resources that require assigning youngsters labels that convey severe pathology. Reimbursement for mental health and special education interventions is tied to such diagnoses. This fact dramatically illustrates how social policy shapes decisions about who receives assistance and the ways in which problems are addressed. It also represents a major ethical dilemma for practitioners. That dilemma is not whether to use labels, but rather how to resist the pressure to inappropriately use those labels that yield reimbursement from third party payers.

BEST COPY AVAILABLE

Programmatic Approaches: Going Beyond Clinical Interventions to Address the Full Range of Problems

A large number of young people are unhappy and emotionally upset; only a small percent are clinically depressed. A large number of youngsters behave in ways that distress others; only a small percent have ADHD or a conduct disorder. In some schools, the majority of students have garden variety learning problems; only a few have learning disabilities. Thankfully, those suffering from true internal pathology (those referred to here as Type III problems) represent a relatively small segment of the population. Society must never stop providing the best services it can for such individuals and doing so means taking great care not to misdiagnose others whose "symptoms" may be similar but are caused to a significant degree by factors other than internal pathology (those referred to above as Type I and II problems). Such misdiagnoses lead to policies and practices that exhaust available resources in serving a relatively small percent of those in need. That is a major reason why there are so few resources to address the barriers interfering with the education and healthy development of so many youngsters who are seen as troubled and troubling.

> Because behavior, emotional, and learning problems usually are labelled in ways that overemphasize internal pathology, it is not surprising that helping strategies take the form of clinical/remedial intervention. And for the most part, such interventions are developed and function in relative isolation of each other.

Thus, they represent another instance of using piecemeal and fragmented strategies to address complex problems.

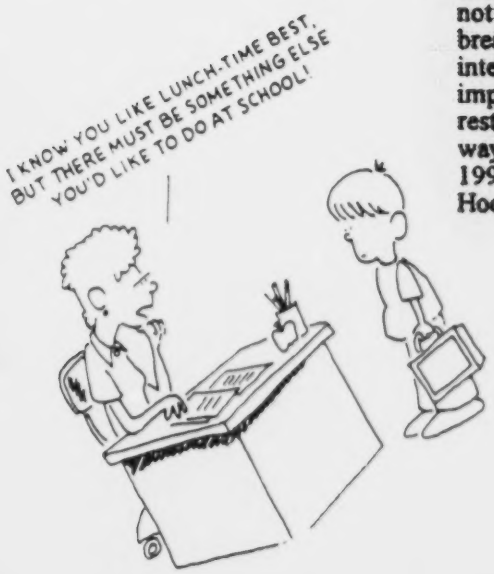
> One result is that an individual identified as having several problems may be involved in programs with several professionals working independently of each other. Similarly, a youngster identified and treated in special infant and pre-school programs who still requires special support may cease to receive appropriate help upon entering school. And so forth.

BEST COPY AVAILABLE

Dealing with the full continuum of Type I, II, and III problems requires a comprehensive and integrated programmatic approach. Such an approach may require one or more mental health, physical health, and social services. That is, any one of the problems may require the efforts of several programs, concurrently and over time. This is even more likely to be the case when an individual has more than one problem. And, in any instance where more than one program is indicated, it is evident that interventions should be coordinated and, if feasible, integrated.

Establishing a comprehensive, integrated approach is excruciatingly hard. Efforts to do so are handicapped by the way interventions are conceived and organized and the way professionals understand their functions. Conceptually, intervention rarely is envisioned comprehensively. Organizationally, the tendency is for policy makers to mandate and planners and developers to focus on specific programs. Functionally, most practitioners and researchers spend most of their time working directly with specific interventions and samples and give little thought or time to comprehensive models or mechanisms for program development and collaboration. Consequently, programs to address physical, mental health, and psychosocial problems rarely are coordinated with each other or with educational programs.

Limited efficacy seems inevitable as long as the full continuum of necessary programs is unavailable; limited cost effectiveness seems inevitable as long as related interventions are carried out in isolation of each other. Given all this, it is not surprising that many in the field doubt that major breakthroughs can occur without a comprehensive and integrated programmatic thrust. Such views have added impetus to major initiatives are underway designed to restructure community health and human services and the way schools operate (Adelman, 1996; Adler & Gardner, 1994; Center for the Future of Children Staff, 1992; Hodgkinson, 1989; Taylor & Adelman, 1996).



BEST COPY AVAILABLE

STOP. THINK. DISCUSS

Here's what one school-based psychiatrist has to say. *Do you agree or disagree with him?*

It happens several times a week in my practice of community child and adolescent psychiatry: Our society's overwhelming belief in medically controlling our kids' behavior finds expression in ever more Huxleyesque demands on the psychiatrist to prescribe. This week's winners are the school district, the juvenile court, and a religious shelter for homeless families with children. Their respective would-be victims are LaShondra, Trevor, and Jimmy.

Jimmy is a 9 year old boy with a long history of treatment for severe emotional disturbance. He's in a school-based day treatment program and seems to be making terrific progress on self-managing his behavior. This turnaround has occurred just in the past few weeks, following an acute psychiatric hospital stay during which the many psychotropic medications he'd been taking without apparent benefit were tapered and discontinued. He was discharged to the day treatment facility and is receiving case management and therapeutic services at home in the community. Unfortunately, the grandmother with whom he lives has been evicted from her residence, and has applied for assistance to a homeless family program. She and Jimmy are scheduled to be admitted to a shelter program next week, but the shelter has made it a condition of receiving services that Jimmy be on medication.

LaShondra is 14. She is in special education classes at her junior high school because of mild mental retardation and emotional disturbance. She bears both physical and psychic scars of early prolonged abuse, and has symptoms of borderline personality pathology and PTSD. She likes school and wants to learn, but keeps getting expelled for behavioral outbursts. The school, too, has made it a condition of her readmittance to classes that she be on medication. LaShondra experiences psychotropic medication as inimical to her emerging adolescent autonomy, and has had negative therapeutic effects during past trials of treatment.

Trevor, at 15, is incarcerated in the Juvenile Detention Center, awaiting a hearing on certification to stand trial as an adult on two charges of capital murder. We have evaluated him for fitness to proceed and determined that he's not mentally ill, but are involved in providing services to Trevor in consultation with the juvenile authorities because he is persistently threatening suicide. We think the best plan is to keep him closely supervised in detention, but the juvenile department is concerned about their liability and petition the court to transfer him to a psychiatric hospital. Two hearings are held on the same day. At the first hearing Trevor is committed to a private facility, on condition that the facility accepts the admission. The facility refuses. At the second hearing, Trevor is committed to the state hospital on condition that the hospital certifies that they can guarantee security. The hospital can't. The Court then orders that Trevor be involuntarily administered unspecified psychotropic agents by injection.

I am not making these things up. These three cases have so far occupied the last three days of my week, and I'm telling you about them not to garner sympathy for the kids (only two of whom have any sympathy coming in any case), or for me (despite my clearly deserving some), but to focus attention on the astonishing degree to which everyone in our society has come to believe in the prescribing of psychotropic medication as a cure, or at least a control, for disturbing behavior in kids.

How did we arrive at this state of affairs? Though a very complex interaction among a myriad of scientific, social, and historical factors, of which I want to mention just two of the scientific ones: progress in psychiatric nosology, and progress in biological psychiatry.

Since 1980, we've trained a generation or two of psychiatrists in the phenomenological approach to diagnosis. The last three editions of the DSM (III-R, and IV) are determinedly atheoretical and empirical in their approach (the majority of members of the Work Groups on Child and Adolescent Disorders for the last three DSM's have been pediatric psychopharmacology researchers), and I think we have long since abandoned trying to teach residents to think about the meanings of symptoms to patients (and ourselves), about the dynamics of intrapsychic structure and interpersonal process. During the same time, the explosive growth of neuroscience and pharmacology has given us many new tools with which to work (if only we knew how: my friend and teacher Bob Beavers used to say, "if the only tool you have is a hammer, everything looks like a nail to you!").

In short, I think we've unwittingly relinquished our most powerful and proven tool: appropriately affectionate, professionally respectful, intimate personal engagement of the patient in mutual exploration of inner meanings. We're frittering our therapeutic potency away on serial trials of psychotropic drugs, and we're prescribing for patients when we don't know the person. There are too many kids on too many drugs, and many of the kids have been given medication as a substitute for engagement and exploration of personal issues.

The point I'm trying to make is that every sector of today's society contributes to this pressure to prescribe. Parents believe medication will cure, schools believe it, courts believe it. even nonpsychiatric mental health professionals believe it. Well, I don't believe it, and it's been my experience with ASAP that most of our members don't believe it either. And, if not only do we not believe that medicine cures, but also we do believe that we have a more powerful and effective treatment which provides an essential context for medication to be helpful, let's stand up and say so. I look forward to hearing from y'all: agree or disagree.

Psychiatrist Glen Pearson is president of the American Society for Adolescent Psychiatry (ASAP). Reprinted with permission.

BEST COPY AVAILABLE

Needed: A Full Continuum of Programs and Services

School health programs always have been concerned with more than offering clinical services. And over the last decade, leaders in the field have advocated for an eight component model to ensure schools have a comprehensive focus on health (Allensworth & Kolbe, 1987; Kolbe, 1986). The components are (1) health education, (2) health services, (3) biophysical and psychosocial environments, (4) counseling, psychological, and social services, (5) integrated efforts of schools and communities to improve health, (6) food service, (7) physical education and physical activity, and (8) health programs for faculty and staff.

> The focus on comprehensive school health is admirable. It is not, of course, a comprehensive approach for addressing a full range of barriers to learning -- nor does it profess to be. Moreover, its restricted emphasis on health tends to engender resistance from school policy makers who do not think they can afford a comprehensive focus on health and still accomplish their primary mission to educate students.

Reform-minded policy makers may be more open to proposals encompassing a broad range of programs to enhance healthy development if such programs are part of a comprehensive approach for addressing barriers to learning.

> Some are suggesting that the *school-linked services* movement, especially in the form of full service schools is the answer. And each day brings additional reports from projects such as New Jersey's School-Based Youth Services Program, the Healthy Start Initiative in California, the Beacons Schools in New York, Cities-in-Schools, and the New Futures Initiative.

A review by Michael Knapp (1995) underscores the fact that the literature on school-linked services is heavy on advocacy and prescription and light on findings. Not surprisingly, findings primarily reflect how hard it is to institutionalize such approaches.

Keeping the difficulties in mind, a reasonable inference from available data is that school-community collaborations can be successful and cost effective over the long-run.

> Outstationing community agency staff at schools allows easier access for students and families -- especially in areas with underserved and hard to reach populations. Such efforts not only provide services, they seem to encourage schools to open their doors in ways that enhance family involvement. Analyses suggest better outcomes are associated with empowering children and families and having the capability to address diverse constituencies and contexts. Families using school-based centers are described as becoming interested in contributing to school and community by providing social support networks for new students and families, teaching each other coping skills, participating in school governance, and helping create a psychological sense of community.

At the same time, it is clear that initiatives for school-linked services produce tension between school district *pupil services personnel* and their counterparts in community-based organizations.

> When "outside" professionals are brought in, school specialist staff often view the move as discounting their skills and threatening their jobs. These concerns are aggravated whenever policy makers appear to overestimate the promise of school-linked services with regard to addressing the full range of barriers to learning. And, ironically, by downplaying school-owned resources, the school-linked services movement has allowed educators to ignore the need for restructuring the various education support programs and services that schools own and operate.

With respect to addressing barriers to learning, comprehensiveness requires more than

- *a focus on health and social services*
- *outreach to* link with *community* resources
- *coordination* of *school-owned* services
- *coordination* of *school and community* services.

Moving toward comprehensiveness in addressing barriers to learning encompasses restructuring, transforming, and enhancing

- all relevant school-owned programs and services
- community resources

and

- weaving these school and community resources together.

BEST COPY AVAILABLE

A continuum is outlined on the following page to illustrate the comprehensive range of programs needed to address Type I, II, and III problems.

> As can be seen, the continuum ranges from programs for primary prevention (including the promotion of mental health) and early-age intervention --through those for addressing problems soon after onset-- on to treatments for severe and chronic problems.
>
> In doing so, it encompasses prevention and prereferral interventions for mild problems, high visibility programs for high-frequency psychosocial problems, and strategies to assist with severe and pervasive mental health problems.

Such an approach recognizes the role school, home, and community life play in creating and correcting young people's problems, especially those who are under-served and hard-to-reach.

> With respect to *comprehensiveness*, the programs outlined highlight that many problems must be addressed developmentally and with a range of programs -- some focused on individuals and some on environmental systems, some focused on mental health and some on physical health, education, and social services. With respect to concerns about *integrating* programs, the continuum underscores the need for concurrent interprogram linkages and for linkages over extended periods of time.

From such a perspective, schools must provide interventions that address individual problems and system changes. At the same time, schools must continue to explore formal and informal ways to link with public and private community agencies.

From Primary Prevention to Treatment of Serious Problems: A Continuum of Community-School Programs to Address Barriers to Learning and Enhance Healthy Development

Intervention Continuum

Examples of Focus and Types of Intervention
(Programs and services aimed at system changes and individual needs)

Primary prevention

1. Public health protection, promotion, and maintenance to foster opportunities, positive development, and wellness
   - economic enhancement of those living in poverty (e.g., work/welfare programs)
   - safety (e.g., instruction, regulations, lead abatement programs)
   - physical and mental health (incl. healthy start initiatives, immunizations, dental care, substance abuse prevention, violence prevention, health/mental health education, sex education and family planning, recreation, social services to access basic living resources, and so forth)

2. Preschool-age support and assistance to enhance health and psychosocial development
   - systems' enhancement through multidisciplinary team work, consultation, and staff development
   - education and social support for parents of preschoolers
   - quality day care
   - quality early education
   - appropriate screening and amelioration of physical and mental health and psychosocial problems

Early-after-onset intervention

3. Early-schooling targeted interventions
   - orientations, welcoming and transition support into school and community life for students and their families (especially immigrants)
   - support and guidance to ameliorate school adjustment problems
   - personalized instruction in the primary grades
   - additional support to address specific learning problems
   - parent involvement in problem solving
   - comprehensive and accessible psychosocial and physical and mental health programs (incl. a focus on community and home violence and other problems identified through community needs assessment)

4. Improvement and augmentation of ongoing regular support
   - enhance systems through multidisciplinary team work, consultation, and staff development
   - preparation and support for school and life transitions
   - teaching "basics" of support and remediation to regular teachers (incl. use of available resource personnel, peer and volunteer support)
   - parent involvement in problem solving
   - resource support for parents-in-need (incl. assistance in finding work, legal aid, ESL and citizenship classes, and so forth)
   - comprehensive and accessible psychosocial and physical and mental health interventions (incl. health and physical education, recreation, violence reduction programs, and so forth)
   - Academic guidance and assistance
   - Emergency and crisis prevention and response mechanisms

5. Other interventions prior to referral for intensive and ongoing targeted treatments
   - enhance systems through multidisciplinary team work, consultation, and staff development
   - short-term specialized interventions (including resource teacher instruction and family mobilization; programs for suicide prevention, pregnant minors, substance abusers, gang members, and other potential dropouts)

Treatment for severe/chronic problems

6. Intensive treatments
   - referral, triage, placement guidance and assistance, case management, and resource coordination
   - family preservation programs and services
   - special education and rehabilitation
   - dropout recovery and follow-up support
   - services for severe-chronic psychosocial/mental/physical health problems

BEST COPY AVAILABLE

REFERENCES

Adelman, H.S. (1996). *Restructuring support services: Toward a comprehensive approach*. Kent, OH: American School Health Association.

Adelman, H.S., Barker, L. A., & Nelson, P. (1993). A study of a school-based clinic: Who uses it and who doesn't? *Journal of Clinical Child Psychology, 22*, 52-59.

Adelman, H.S. & Taylor, L. (1993). *Learning problems and learning disabilities: Moving forward*. Pacific Grove, CA: Brooks/Cole.

Adler, L., & Gardner, S. (Eds.), (1994). *The politics of linking schools and social services*. Washington, DC: Falmer Press.

Allensworth, D. & Kolbe, L. (1987). The comprehensive school health program: Exxploring an expanded concept. *Journal of School Health, 57*, 409-473.

Center for the Future of Children Staff (1992). *The future of children, 2*. 6-18.

Center for Reproductive Health Policy Research (1989). *Annual Report: Evaluation of California's comprehensive school-based health centers*. San Francisco: Center for Reproductive Health Policy Research, Institute for Health Policy Studies, UCSF.

Dryfoos, J.G. (1994). *Full-service schools: A revolution in health and social services for children, youth, and families*. San Francisco: Jossey-Bass.

Dryfoos, J. (1995). Full service schools: Revolution or fad? *Journal of Research on Adolescence, 5*, 147-172.

Hodgkinson, H.L. (1989). *The same client: The demographics of education and service delivery systems*. Washington, DC: Institute for educational Leadership, Inc./Center for Demographic Policy.

Kolbe, L.J. (1986). Increasing the impact of school health programs: Emerging research perspectives. *Health Education, 17*, 47-52.

Knapp, M.S. (1995). How shall we study comprehensive collaborative services for children and families? *Educational Researcher, 24*, 5-16.

Robert Wood Johnson Foundation (1993). *Making the grade: State and local partnerships to establish school-based health centers*. Princeton, NJ: Author.

Robert Wood Johnson Foundation (1989). *Annual Report*. Princeton, NJ: Author.

Ryan, W. (1991). *Blaming the victim*. New York: Random House.

Schlitt, J.J., Rickett, K.D., Montgomery, L.L., & Lear, J. (1994). *State initiatives to support school-based health centers: A national survey*. Washington, DC: Making the Grade.

Taylor, L., & Adelman, H.S. (1996). Mental health in schools: Promising directions for practice. *Adolescent Medicine: State of the Art Reviews, 7*, 303-317.

BEST COPY AVAILABLE

Test Questions -- Unit I: Section C

(1) Which of the following are implications of understanding a student's problems in terms of a causal continuum that ranges from internal to external causes?

___(a) some problems primarily result from biological or psychological factors
___(b) some problems primarily result from environmental causes
___(c) some problems are caused by the environment not accommodating individual differences and vulnerabilities
___(d) a and b
___(e) all of the above
___(f) none of the above

(2) Improving the way the environment accommodates individual differences may be a sufficient intervention strategy.

_____True _____False

(3) School-Based Health Centers have come to find it necessary to address mental health and psychosocial concerns because

___(a) mental health is more important than physical health
___(b) many students physical complaints are psychogenic
___(c) mental health services are less costly
___(d) many students come to the centers for help with psychosocial problems
___(e) a and b
___(f) a and c
___(g) b and d
___(h) all of the above

(4) With respect to addressing barriers to learning, a comprehensive approach requires more than a focus on health and social services.

_____True _____False

(5) A comprehensive approach to addressing barriers to learning is achieved by outreaching to link with community resources.

_____True _____False

(6) With respect to addressing barriers to learning, a comprehensive approach requires more than coordination of school and community services.

_____True _____False

(7) Moving toward comprehensiveness in addressing barriers to learning encompasses restructuring, transforming, and enhancing (a) relevant school-owned programs and services, (b) community resources, and (c) weaving these school and community resources together.

_____True _____False

Coda: A Wide Range of Responses for a Wide Range of Problems

Most schools and many community services use weak models in addressing barriers to learning. The primary emphasis in too many instances is to refer individuals to specific professionals, and this usually results in narrow and piecemeal approaches to complex problems, many of which find their roots in a student's environment. Overreliance on referrals to professionals also inevitably overwhelms limited, public-funded resources.

> More ideal models emphasize the need for a comprehensive continuum of community and school interventions to ameliorate complex problems. Such a continuum ranges from programs for primary prevention and early-age intervention -- through those to treat problems soon after onset -- to treatments for severe and chronic problems. Thus, they emphasize that promoting healthy development and positive functioning are one of the best ways to prevent many problems, and they also address specific problems experienced by youth and their families.

To be most effective, such interventions are developmentally-oriented (i.e., beginning before birth and progressing through each level of schooling and beyond) and offer a range of activity -- some focused on individuals and some on environmental systems. Included are programs designed to promote and maintain safety at home and at school, programs to promote and maintain physical/mental health, preschool and early school adjustment programs, programs to improve and augment social and academic supports, programs to intervene prior to referral for intensive treatments, and intensive treatment programs. It should be evident that such a continuum requires meshing together school and community resources and, given the scope of activity, effectiveness and efficiency require formal and long-lasting interprogram collaboration.

> One implication of all this is formulated as the proposition that *a comprehensive, integrated component to address barriers to learning and enhance healthy development is essential* in helping the many who are not benefitting satisfactorily from formal education. Schools and communities are beginning to sense the need to adopt such a perspective. As they do, we will become more effective in our efforts to enable schools to teach, students to learn, families to function constructively, and communities to serve and protect. Such efforts will no longer be treated as supplementary ("add-ons") that are carried out as fragmented and categorical services; indeed, they will be seen as a primary, essential, and integrated component of school reform and restructuring.

ADDRESSING BARRIERS TO LEARNING: NEW DIRECTIONS FOR MENTAL HEALTH IN SCHOOLS

Unit II:

Mental Health Services & Instruction: What a School Can Do

Sections

A. Screening and Assessment

B. Problem Response and Prevention

C. Consent, Due Process, and Confidentiality

Deciding what is best for a child often poses a question no less ultimate than the purposes and values of life itself.

Robert Mnookin

This unit is one of a set of three focused on the role of schools in addressing psychosocial and mental health problems that interfere with students' learning and performance.

When it comes to mental health and psychosocial problems, a school's staff doesn't have to look very hard to find them. Currently, the function of many specialists in schools is to deal with such problems by providing *direct services and instruction.*

Effective pursuit of such functions requires working with others to enhance services and programs. This encompasses efforts to *coordinate, develop, and provide leadership related to relevant programs, services, resources, and systems.* It also involves *enhancing connections with community resources.*

Because they are inundated with students who need assistance for mental health and psychosocial concerns, a key service many schools find themselves providing is the *identification and processing* of such students. Major tasks in carrying out this service are

- initial problem identification
- screening/assessment
- client consultation and referral
- triage
- initial case monitoring.

Schools also must be prepared to *respond to students' psychological crises*. And with respect to *primary prevention and treatment*, they often find themselves providing

- mental health education
- psychosocial guidance and support (classroom/individual)
- psychosocial counseling.

School staff also are a valuable resource for *ongoing case monitoring.*

ADDRESSING BARRIERS TO LEARNING: NEW DIRECTIONS FOR MENTAL HEALTH IN SCHOOLS

Contents of All Three Units

I. Placing Mental Health into the Context of Schools and the 21st Century

A. Introductory Overview
B. The Need to Enhance Healthy Development and Address Barriers to Learning
C. Addressing the Need: Moving Toward a Comprehensive Approach
Coda: A Wide Range of Responses for a Wide Range of Problems

II. Mental Health Services & Instruction: What a School Can Do

A. Screening and Assessment

Initial Problem Identification
Connecting a Student with the Right Help
Screening to Clarify Need
Client Consultation and Referral
Triage
Initial Case Monitoring

B. Problem Response and Prevention

Psychological First Aid: Responding to a Student in Crisis
Primary Prevention and Treatment
Mental Health Education
Psychosocial Guidance and Support
Psychosocial Counseling
Ongoing Case Monitoring
To Review

C. Consent, Due Process, and Confidentiality

Coda: Networks of Care

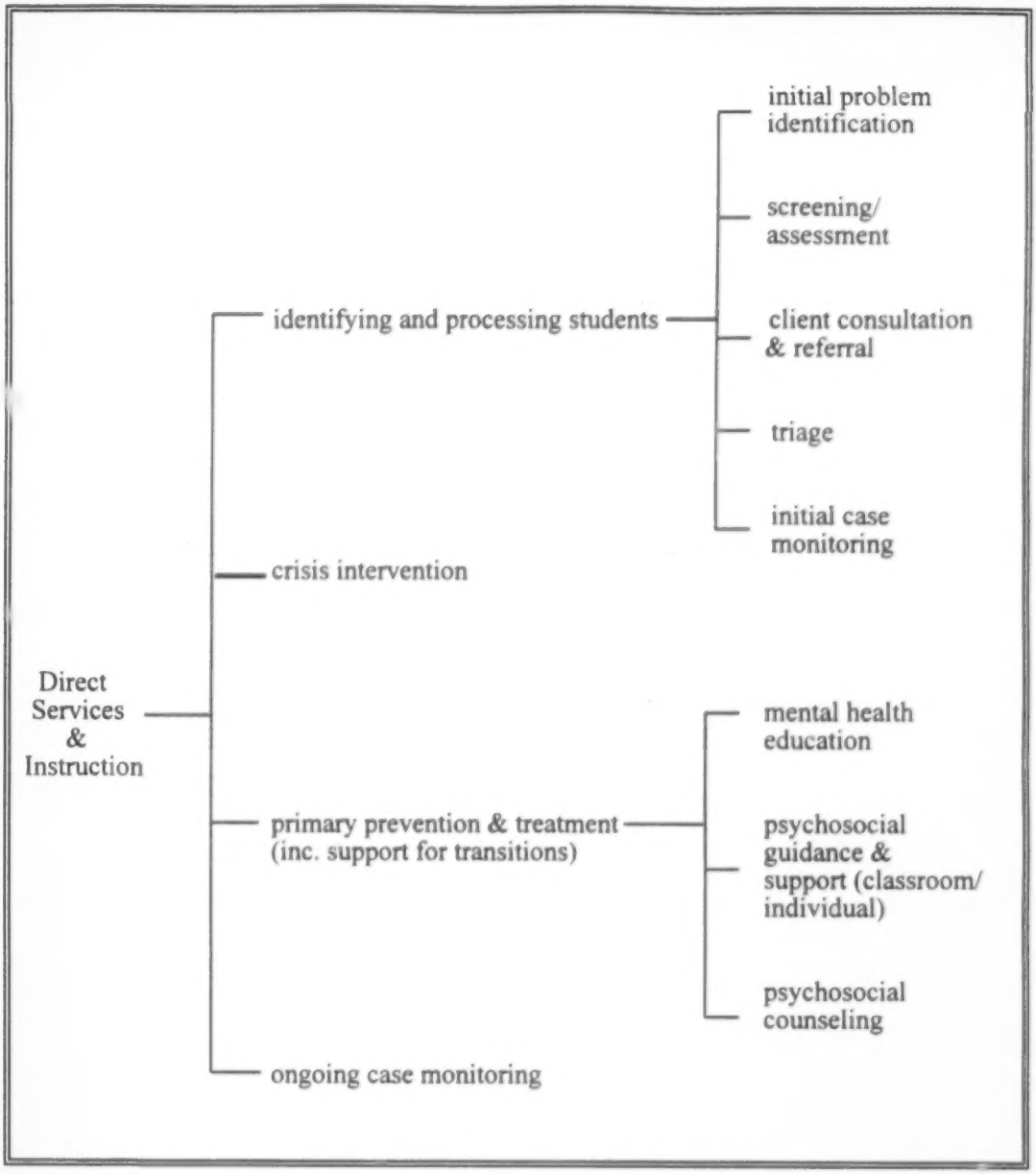
Follow-Up Reading
•*ABCs of Assessment*
•*Managing and Preventing School Misbehavior and School Avoidance*

III. Working with Others to Enhance Programs and Resources

A. Working Relationships
B. Working to Enhance Existing Programs
C. Building a Comprehensive, Integrated Approach at Your School
Coda: New Roles for Schools: A Multifaceted Focus

Glossary of Key Terms, Acronyms, and Laws

Section A: Screening and Assessment



Contents:

Initial Problem Identification
Connecting a Student with the Right Help
Screening to Clarify Need
Client Consultation and Referral
Triage
Initial Case Monitoring

Objectives for Section A

After completing this section of Unit II, you should be able to:

- *explain what is involved in the process of identifying and processing* students in need of assistance for mental health and psychosocial problems and identify five specific facets of the process

- know of and be able to use at least two instruments for screening psychosocial and mental health problems

A Few Focusing Questions

- *What is the school's role in the initial identification of students who may have psychosocial and mental health problems?*
- *Once a student is identified as having problems, what screening activity can a school do to help clarify the nature and severity of the problems?*
- *What are the purposes and processes of client consultation, referral, triage, and initial case monitoring?*

BEST COPY AVAILABLE

Initial Problem Identification

Support staff identify many mental health problems each. Problems come to their attention during attendance and discipline reviews, assessments for special education placement, and related to crisis interventions, or as a result of others (staff, parents, students) raising concerns about a given youngster.

In this last respect, part of a their job may be to educate teachers, peers, parents, and others about appropriately identifying and referring students.

And, of course, some students come seeking help for themselves.

How should you handle all this?

If there are accessible referral resources at the school (e.g., a school psychologist, a counselor, a social worker, a school-based health center with a mental health professional) or in the community, the answer *may* be to help a student connect with such an individual -- assuming it is not something you can handle without making a referral.

Of course, when other professionals are not available or when a student will not follow-through, your only choice is to decide whether to do something more yourself.

If you decide to proceed, you will want to *assess* the problem for purposes of triage and consulting with the student and concerned others.

Note: As a follow-up aids for you and your school, included in the accompanying materials are two resource packets prepared by the Center for Mental Health in Schools at UCLA. One is entitled *Screening/Assessing Students: Indicators and Tools* and the other focuses on *Substance Abuse*. Both include instruments you can use and provide further discussion of what to look for in screening. Examples of some tools from these packets are included at the end of this section.

STOP. THINK. DISCUSS

What's a parent to do?

Joan, the nurse for Cates Elementary School, first encountered Matt Johnson when he was sent to her by his teacher because he said his stomach was upset. As best Joan could tell, there was no reason to think the problem was serious. She let the boy rest a while and then sent him back to class. Over the next two weeks, he was sent to her three more times with varying minor somatic complaints. At this point, she met with the teacher, and they decided the teacher should call Matt's home.

Matt's mother was not surprised to hear from the school. Mrs. Johnson had been to school for several conferences during the month because of her son's poor classroom functioning and behavior. She said she thought Matt's complaints probably were a way of getting out of class. It was a pattern the mother had seen before, both with Matt and her other child. Mrs. Johnson stressed that a recent doctor's exam had not turned up any physical problems. She also noted that Matt's counselor had told her to monitor his homework more closely and discipline him more consistently for misbehavior. But when she had tried to do so, Matt's rebellious behavior increased. She wasn't sure what to do. In a voice that was partially a plea and very much a challenge, she asked: *Do you have any suggestions?*

What has been your experience with situations of this type?

What should a school do in such circumstances?

Connecting a Student with the Right Help

The process of connecting the student with appropriate help can be viewed as encompassing four facets:

(1) screening/assessment

(2) client consultation and referral

(3) triage

(4) initial case monitoring.

TEACHER: *Yes, Chris, what is it?*
CHRIS: *I don't want to scare you, but my Dad says if I don't get better grades someone is due for a spanking.*

---

(1) *Screening to Clarify Need*

Most of the time it will not be immediately evident what the source of a student's problems are or how severe or pervasive they are. As you know, the causes of behavior, learning, and emotional problems are hard to analyze. What looks like a learning disability or an attentional problem may be emotionally-based; behavior problems and hyperactivity often arise in reaction to learning difficulties; problems with schooling may be due to problems at home, reactions to traumatic events, substance abuse, and so forth. It is especially hard to know the underlying cause of a problem at school when a student is unmotivated to learn and perform.

This, then, becomes the focus of initial assessment -- which essentially is a screening process. Such screening can be used to clarify and validate the nature, extent, and severity of a problem. It also can determine the student's motivation for working on the problem. If the problem involves significant others, such as family members, this also can be explored to determine the need for and feasibility of parental and family counseling.

Screening: A Note of Caution

Formal screening to identify students who have problems or who are "at risk" is accomplished through individual or group procedures. Most such procedures are *first-level* screens and are expected to *over identify* problems. That is, they identify many students who do not really have significant problems (false positive errors). This certainly is the case for screens used with infants and primary grade children, but false positives are not uncommon when adolescents are screened. Errors are supposed to be detected by follow-up assessments.

> Because of the frequency of false positive errors, serious concerns arise when screening data are used to diagnose students and prescribe remediation and special treatment. Screening data primarily are meant to sensitize responsible professionals. No one wants to ignore indicators of significant problems. At the same time, there is a need to guard against tendencies to see *normal variations* in student's development and behavior as problems.

Screens do not allow for definitive statements about a student's problems and need. At best, most screening procedures provide a preliminary indication that something may be wrong. In considering formal diagnosis and prescriptions for how to correct the problem, one needs data from assessment procedures that have greater validity.

> It is essential to remember that many factors that are symptoms of problems also are common characteristics of young people, especially in adolescence. Cultural differences also can be misinterpreted as symptoms. To avoid misidentification that can inappropriately stigmatize a youngster, all screeners must take care not to overestimate the significance of a few indicators and must be sensitive to developmental, cultural, and other common individual differences.

A Few Comments on Screening/Assessment and Diagnosis

- When someone raises concerns about a student with you, one of the best tools you can have is a structured referral form for them to fill out. This encourages the referrer to provide you with some detailed information about the nature and scope of the problem. An example of such a form is provided at the end of this section.

- To expand your analysis of the problem, you will want to gather other available information. It is good practice to gather information from several sources -- including the student. Useful sources are teachers, administrators, parents, sometimes peers, etc. If feasible and appropriate, a classroom observation and a home visit also may be of use. You will find some helpful tools in the accompanying materials.

- And you can do a screening interview. The nature of this interview will vary depending on the age of the student and whether concerns raised are general ones about misbehavior and poor school performance or specific concerns about lack of attention, overactivity, major learning problems, significant emotional problems such as appearing depressed and possibly suicidal, or about physical, sexual, or substance abuse. To balance the picture, it is important to look for assets as well as weaknesses. (In this regard, because some students are reluctant to talk about their problems, it is useful to think about the matter of talking with and listening to students -- more on this in Section II-B.)

- In doing all this, you will want to try to clarify the role of environmental factors in contributing to the student's problems.

Remember:

- Students often somaticize stress; and, of course, some behavioral and emotional symptoms stem from physical problems.

- Just because the student is having problems doesn't mean that the student has a pathological disorder.

- The student may just be a bit immature or exhibiting behavior that is fairly common at a particular development stage. Moreover, age, severity, pervasiveness, and chronicity are important considerations in diagnosis of mental health and psychosocial problems. The following are a few examples to underscore these points.

Age	*Common Transient Problem*	*Low Frequency Serious Disorder*
0-3	Concern about monsters under the bed	Sleep Behavior Disorder
3-5	Anxious about separating from parent	Separation Anxiety Disorder (crying & clinging)
5-8	Shy and anxious with peers (sometimes with somatic complaints)	Reactive Attachment Disorder
	Disobedient, temper outbursts	Conduct Disorder Oppositional Defiant Disorder
	Very active and doesn't follow directions	Attention Deficit-Hyperactivity Disorder
	Has trouble learning at school	Learning Disabilities
8-12	Low self-esteem	Depression
12-15	Defiant/reactive	Oppositional Defiant Disorder
	Worries a lot	Depression
15-18	Experimental substance use	Substance Abuse

- The source of the problem may be stressors in the classroom, home, and/or neighborhood. (Has the student's environment been seriously looked at as the possible culprit?)

- At this stage, assessment is really a *screening* process such as you do when you use an eye chart to screen for potential vision problems. If the screening suggests the need, the next step is referral to someone who can do indepth assessment to determine whether the problem is diagnosable for special education and perhaps as a mental disorder. To be of value, such an assessment should lead to some form of prescribed treatment, either at the school or in the community. In many cases, ongoing support will be indicated, and hopefully the school can play a meaningful role in this regard.

(2) *Client Consultation and Referral*

When someone becomes concerned about a student's problems, one of the most important roles to play is assisting the individual in connecting directly with someone who can help. This involves more than referring the student or parents to a resource. The process is one of turning referral procedures into an effective intervention in and of itself.

Minimally, such an intervention encompasses consultation with the concerned parties, assisting them by detailing the steps involved in connecting with potential referral resources, and following-up to be certain of follow-through. It may also include cultivating referral resources so that you can maximize their responsiveness to your referrals.

Using all the information you have gathered, it is time to sit down with those concerned (student, family, other school staff) and explore what seems to be wrong and what to do about it.

Such consultation sessions are part of a shared problem solving process during which you provide support by assisting the involved parties in

- analyzing the problem (Are environmental factors a concern? Are there concerns about underlying disorders?)
- laying out alternatives (clarifying options/what's available)
- deciding on a course of action (evaluating costs vs. benefits of various alternatives for meeting needs)

Finally, it is essential to work out a sound plan for ensuring there is follow-through on decisions.

A Few Comments on Client Consultation and Referral

Referrals are relatively easy to make; *appropriate* referrals are harder; and *ensuring follow-through* is the most difficult thing of all.

> Appropriate referrals are made through a consultation process that is consumer oriented and user friendly. They also are designed as a transition-type intervention; that is, recognizing that many students/families are reluctant to follow-through on a referral, they include procedures that support follow-through.

A consumer oriented system is designed with full appreciation of the nature and scope of student problems as perceived by students, their families, and their teachers. Such problems range from minor ones that can be dealt with by providing direct information, perhaps accompanied by some instruction to severe/pervasive/chronic conditions that require intensive intervention.

> The process must not ignore the social bases of a student's problems. This means attending to environmental concerns such as basic housing and daily survival needs, family and peer relations, and school experiences. A student's needs may range from accessing adequate clothes to acquiring protection from the harassment of gang members. In many instances, the need is not for a referral but for mobilizing the school staff to address how they might improve its programs to expand students' opportunities in ways that increase expectations about a positive future and thereby counter prevailing student frustration, unhappiness, apathy, and hopelessness.

A consumer oriented system should minimally

- provide readily accessible basic information about relevant resources
- help students/families appreciate the need for and value of a potential resource
- account for problems of access (e.g., cost, location, language and cultural sensitivity)
- aid students/families in reviewing their options and making decisions in their own best interests
- provide sufficient support and guidance to enable students/families to connect with a referral resource
- follow-up with students/families (and referrers) to determine whether referral decisions were appropriate.

Thinking in terms of intervention steps, a good consultation and referral process helps you do the following:

(1) *Provide ways for students/families and school personnel to learn about existing resources*

This entails widespread circulation of general information about on- and off-campus programs and services and ways to readily access such resources.

(2) *Establish whether a referral is necessary*

This requires an analysis of whether current resources can be modified to address the need.

(3) *Identify potential referral options with the student/family*

Review with the student/family how referral options can assist. A resource file and handouts can be developed to aid in identifying and providing information about appropriate services and programs -- on and off-campus -- for specific types of concerns (e.g., individual/group/family/professional or peer counseling for psychological, drug and alcohol problems, hospitalization for suicide prevention). Remember that many students benefit from group counseling. And, if a student's problems are based mainly in the home, one or both parents may need counseling -- with or without the student's involvement as appropriate. Of course, if the parents won't pursue counseling for themselves, the student may need help to cope with and minimize the impact of the negative home situation. Examples of materials that can provide students, families, and staff with ready references to key resources are provided in the accompanying Resource Aid Packet on *Client Consultation and Referral: a Transition Intervention*.

(4) *Analyze options with student/family and help with decision-making as to which are the most appropriate resources*

This involves evaluating the pros and cons of potential options (including location, fees, least restrictive and intrusive intervention needed) and, if more than one option emerges as promising, rank ordering them. For example, because students often are reluctant to follow-through with off-campus referrals, first consideration may be given to those on-campus, then to off-campus district programs, and finally to those offered by community agencies. Off-campus referrals are made with due recognition of school district policies.

(5) *Identify and explore with the student/family all factors that might be potential barriers to pursuing the most appropriate option*

Is there a financial problem? a transportation problem? a problem about parental consent? too much anxiety/fear/apathy? At this point, it is wise to be certain that the student (and where appropriate the family) truly feels an intervention will be a good way to meet her or his needs.

(6) *Work on strategies for dealing with barriers to follow-through*

This often overlooked step is essential to follow-through. It entails taking the time to clarify specific ways to deal with apparent barriers.

(7) *Send the student/family off with a written summary of what was decided including follow-through strategies*

A referral decision form can summarize (a) specific directions about enrolling in the first choice resource, (b) how to deal with problems that might interfere with successful enrollment, and (c) what to do if the first choice doesn't work out. A copy of such a form can be kept on file for purposes of case monitoring.

(8) *Also send them off with a follow-through status report form*

Such a form is intended to let the school know whether the referral worked out, and if not, whether additional help is called for in connecting the student/family to needed resources. Also, remember that teachers and other school staff who asked you to see a student will want to know that something was done. Without violating any confidentiality considerations, you can and should send them a quick response reassuring them that the process is proceeding.

(9) *Follow-through with student/family and other concerned parties to determine current status of needs and whether previous decision were appropriate*

This requires establishing a reminder (tickler) system so that a follow-up is made after an appropriate period of time.

Obviously, the above steps may require more than one session with a student/family and may have to be repeated if there is a problem with follow-through. In many cases, one must take specific steps to help with follow through, such as making direct connections (e.g., by phone) to the intake coordinator for a program. Extreme cases may require extreme measures such as arranging for transportation or for someone to actually go along to facilitate enrollment.

Increasingly, as a way to minimize the flood of referrals from teachers, what are called *prereferral interventions* are being stressed. These represent efforts to help students whose problems are not too severe by improving how teachers, peers, and families provide support. A particular emphasis in enhancing prereferral efforts is on providing staff support and consultation to help teachers and other staff learn new ways to work with students who manifest "garden variety" behavior, learning, and emotional problems. Over time, such a staff development emphasis can evolve into broader stakeholder development, in which all certificated and classified staff, family members, volunteers, and peer helpers are taught additional strategies for working with those who manifest problems.

(3) *Triage*

Problems that are mild to moderate often can be addressed through participation in programs that do not require special referral for admission. Examples are regular curriculum programs designed to foster positive mental health and socio-emotional functioning; social, recreational, and other enrichment activities; and self-help and mutual support programs. Because anyone can apply directly, such interventions can be described as *open-enrollment* programs.

> Given there are never enough resources to serve those with severe problems, it is inevitable that the processing of such students will involve a form of triage (or gatekeeping) at some point.

When referrals are made to on-site resources, it falls to the school to decide which cases need immediate attention and which can be put on a waiting list. Working alone or on a team, a wide range of school staff can play a key role in making this determination.

Referrals are easy to make . . .

An old fable tells of an arthritic Bulgarian peasant and her encounter with a doctor. After an extensive examination, he diagnoses her problem and writes a prescription for medication, details a special diet, and recommends that she have hydrotherapy. The doctor's professional manner and his expert diagnosis and prescription naturally filled the woman with awe, and as she leaves his office, she is overcome with admiration and says the Bulgarian equivalent of "Gee, you're wonderful doctor!"

A few years pass before the doctor runs into the woman again. As soon as she sees him, she rushes up and kisses his hand and thanks him again for his marvelous help. The doctor, of course, is gratified. Indeed, he is so pleased that he fails to notice that she is as crippled as before.

unfortunately, data suggest that follow-through rates for referrals made by staff at school sites are under 50%.

The fact is that the woman never got the medication because she neither had the money nor access to an apothecary. Moreover, her village had no provision for hydrotherapy, and the prescribed diet included too many foods that she either did not like or could not afford.

Nevertheless, despite her continuing pain, she remained full of awe for the wise doctor and praised him to everyone who would listen.

(Adapted from Berne, 1964)

(4) *Initial Case Monitoring*

It is wise to do an immediate check on follow-through (e.g., within 1-2 weeks) to see if the student did connect with the referral. Besides checking with the student/family, it is also a good idea to get a report on follow-through from those to whom referrals are made.

> If there has been no follow-through, the contact can be used to clarify next steps.

If there has been follow-through, the contact can be used to evaluate whether the resource is meeting the need. The opportunity also can be used to determine if there is a need for communication and coordination with others who are involved with the student's welfare. This is the essence of *case management* which encompasses a constant focus to evaluate the appropriateness and effectiveness of the interventions.

> Follow-up checks are indicated periodically. If the findings indicate the student did not successfully enroll or stay in a program or is not doing well, another consultation session can be scheduled to determine next steps.

Remember that from the time a student is first identified as having a problem, there is a need for someone to monitor/manage the case. Monitoring continues until the student's service needs are addressed. Monitoring takes the form of case management to ensure coordination with the efforts of others who are involved (e.g., other services and programs including the efforts of the classroom teacher and those at home). The process encompasses a constant focus to evaluate the appropriateness and effectiveness of the various efforts.

Note: As a follow-up aid for you and your school, included in the accompanying materials is a technical aid packet entitled *School-Based Client Consultation, Referral, and Management of Care* -- prepared by the Center for Mental Health in Schools at UCLA. In this packet and the others mentioned earlier, you will find tools to aid with the various tasks that have been outlined in this section.

STOP. THINK. DISCUSS

Gathering Some Assessment Data

The school nurse asked Mrs. Johnson to have the doctor send her a medical report. Although she was already convinced that Matt's problems were not physical, she wanted some validation.

To get a sense of his past experiences at school, the counselor went to Matt's school records. It was clear from his grades and achievement test scores that the problems at school had not appeared until he entered 4th grade.

The counselor talked with his teacher, Mr. Briggs. He didn't much like Matt but said the boy was smart and that his basic skills were pretty good. He also stressed that, because of the way Matt acted, none of the other students liked him. As far as the teacher was concerned, Matt just needed parents who could control him.

When the counselor told Matt she wanted to talk with him, he wanted to know why. She explained her concerned that things weren't going well for him and that she thought he might have some ideas about how the school could help him make things better. She let him know that he didn't have to talk about anything he didn't want to discuss. She also said they could meet at a time that was good for him. Matt was skeptical, but he agreed to talk with her during math time.

When he appeared at her office, the counselor put a "Conference in Progress" sign on the door and proceeded to engage Matt in a dialogue designed to find out what was wrong and what might be done to help him.

What types of things should a school explore in interviewing a student about psychosocial and mental health concerns?

What is likely to facilitate and what can inhibit student talk during an interview?

ABOUT THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM-IV, 1994)

Because the DSM is so widely used throughout the U.S., school professionals need to have some level of awareness of its focus and the categories that are used with respect to children and adolescents. If you are unfamiliar with this classification scheme, you will find a summary description on the following pages.

About the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, 1994)

Among the purposes of diagnostic systems such as the DSM are to (1) facilitate communication among professionals and (2) standardize criteria for diagnosis.

Multiaxial Assessment

With the intent of capturing a good deal of the complexity of psychological problems, the DSM focuses simultaneously on several dimensions. This effort is referred to as multiaxial assessment. Simply stated, an axis is a dimension to be considered in assessment. Recent versions of the Diagnostic and Statistical Manual of Mental Disorders developed by the American Psychiatric Association (see DSM-IV, 1994) include a focus on five dimensions -- thus the term multiaxial. The five are:

Axis I — *Clinical Disorders* -- the focus is on assessing symptoms to identify whether criteria are met for assigning one of the psychiatric disorders (or other conditions that may be the focus of clinical attention) identified in the DSM-IV classification scheme.

Axis II — *Personality Disorders/Mental Retardation* -- the focus is on facets of an individual's persona or intellectual ability that are likely to be resistant to change.

Axis III — *General Medical Conditions* -- the focus is on any medical conditions that may be contributing to psychological problems or may be a factor in intervention.

Axis IV — *Psychosocial and Environmental Problems* -- the focus is on specific contextual factors that have relevance for conclusions about differential diagnosis, treatment, and prognosis

Axis V — *Global Assessment of Functioning* -- the focus is on how well the individual is presently functioning.

For the four axes (I-IV) that focus on specific areas, the DSM-IV classification scheme provides a range of possible categories and delineates relevant criteria. The categories are:

Axis I

- Disorders usually first diagnosed in infancy, childhood, or adolescence (excluding Mental Retardation, which is diagnosed on Axis II)
- Delirium, dementia, and amnestic and other cognitive disorders
- Mental disorders due to a general medical condition
- Substance-related disorders
- Schizophrenia and other psychotic disorders
- Mood disorders
- Anxiety disorders
- Somatoform disorders
- Factitious disorders
- Dissociative disorders
- Sexual and gender identity disorders
- Eating disorders
- Sleep disorders
- Impulse-control disorders not elsewhere classified
- Adjustment disorders
- Other conditions that may be a focus of clinical attention

Axis II

- Paranoid personality disorders
- Schizoid personality disorders
- Schizotypal personality disorders
- Antisocial personality disorders
- Borderline personality disorders
- Histrionic personality disorders
- Narcissistic personality disorders
- Avoidant personality disorders
- Dependent personality disorders
- Obsessive-compulsive personality disorders
- Personality disorder not otherwise specified
- Mental retardation

Axis III

- Infectious and parasitic diseases
- Neoplasms
- Endocrine, nutritional, and metabolic diseases and immunity disorders
- Diseases of the blood and blood-forming organs
- Diseases of the nervous system and sense organs
- Diseases of the circulatory system
- Diseases of the respiratory system
- Diseases of the digestive system
- Diseases of the genitourinary system
- Complications of pregnancy, childbirth, and the puerperium
- Diseases of the skin and subcutaneous tissue
- Diseases of the musculoskeletal system and connective tissue
- Congenital anomalies
- Certain conditions originating in the perinatal period
- Symptoms, signs, and ill-defined conditions
- Injury and poisoning

Axis IV

- Problems with primary support group
- Problems related to the social environment
- Educational problems
- Occupational problems
- Housing problems
- Economic problems
- Problems with access to health care services
- Problems related to interaction with the legal system/crime
- Other psychosocial and environmental problems

With respect to Axis V (Global Assessment of Functioning), the point is to clarify the level of coping ability/adaptive functioning. The assessor rates the individual on a scale of 1 to 100.

91-100 = superior functioning, no symptoms
81-90 = good functioning, minimal symptoms
71-80 = a few transient and commonplace symptoms
61-70 = mild symptoms but functioning pretty well
51-60 = moderate symptoms and functional problems
41-50 = serious symptoms and impairment in functioning
31-40 = some impairment in reality testing or major impairment in several functional areas
21-30 = delusions or hallucinations or serious impairment in judgment or inability to function
11-20 = some danger of hurting self or others or occasional failure to maintain hygiene
1-10 = persistent danger of severely hurting self or others or inability to maintain hygiene

BEST COPY AVAILABLE

Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence

The following group of categories is of particular interest to those working with young people:

- Mental Retardation (coded on Axis II)[1]
  - mild mental retardation
  - moderate mental retardation
  - severe mental retardation
  - profound mental retardation
  - mental retardation, severity unspecified
- Learning Disorders[1]
  - reading disorder
  - mathematics disorder
  - disorder of written expression
  - learning disorder NOS[2]
- Motor Skills Disorder
  - development coordination disorder
- Communication Disorders
  - expressive language disorder
  - mixed receptive-expressive language disorder
  - phonological disorder
  - stuttering
  - communication disorder NOS
- Pervasive Developmental Disorders
  - autistic disorder
  - Rett's disorder
  - childhood disintegrative disorder
  - Asperger's disorder
  - pervasive developmental disorder NOS
- Attention-Deficit and Disruptive Behavior Disorders
  - attention-deficit/hyperactivity disorder
    - combined type
    - predominantly inattentive type
    - hyperactive-impulsive type
  - attention-deficit hyperactivity disorder NOS
  - conduct disorder (childhood or adolescent-onset)
  - oppositional defiant disorder
  - disruptive behavior disorder
- Feeding and Eating Disorders of Infancy or Early Childhood
  - pica
  - rumination disorder
  - feeding disorder of infancy or early childhood
- Tic Disorders
  - Tourette's disorder
  - chronic motor or vocal tic disorder
  - transient tic disorder
  - tic disorder NOS
- Elimination Disorders
  - encopresis
    - with constipation and overflow incontinence
    - without constipation and overflow incontinence
  - enuresis (not due to a general medical condition) -- nocturnal, diurnal, or both
- Other Disorders of Infancy, Childhood, or Adolescence
  - separation anxiety disorder
  - selective mutism
  - reactive attachment disorder of infancy or early childhood (inhibited or disinhibited)
  - stereotypic movement disorder
  - disorder of infancy, childhood, or adolescence NOS

[1]Diagnoses of mental retardation and learning disorders must be based on use of one or more of the standardized, individually administered intelligence tests. In addition, diagnosis of learning disorders requires use of standardized, individually administered achievement tests in determining the degree of discrepancy between intellectual functioning and achievement.

[2]NOS = Not Otherwise Specified -- As indicated in the DSM: "Because of the diversity of clinical presentations, it is impossible for the diagnostic nomenclature to cover every possible situation. For this reason, each diagnostic class has at least one Not Otherwise Specified (NOS) category and some classes have several...."

Other Categories Used in Diagnosing Child and Adolescent Problems

The following are additional categories often used in diagnosing young people:

- Adjustment Disorder *
  - with depressed mood
  - with anxiety
  - with mixed anxiety and depressed mood
  - with disturbance of conduct
  - with mixed disturbance of emotions and conduct
  - unspecified

  Specify if: acute chronic

*The essential feature of such a disorder is described as "the development of clinically significant emotional or behavioral symptoms in response to an identifiable psychosocial stressor or stressors."

- Anxiety Disorders
  - panic disorder without agrophobia
  - panic disorder with agrophobia
  - agrophobia without history of panic disorder
  - specific phobia (specified)
  - social phobia
  - obsessive-compulsive disorder
  - posttraumatic stress disorder
  - acute stress disorder
  - generalized anxiety disorder
  - anxiety disorder due to ...
    (indicated general medical condition)
  - substance-induced anxiety disorder
  - anxiety disorder NOS

- Mood Disorders

  Depressive Disorders
  - major depressive disorder
    (single episode/recurrent)
  - dysthmic disorder
  - depressive disorder

  Bipolar Disorders
  - bipolar I disorder
  - bipolar II disorder
  - cyclothymic disorder
  - bipolar disorder NOS
  - mood disorder due to ...
    (indicated general medical condition)
  - substance-induced mood disorder
  - mood disorder NOS

- Other Conditions That May Be A Focus of Clinical Attention

  . . .

  Relational Problems
  - relational problem related to a mental disorder or general medical condition
  - parent-child relational problem

  . . .

  - sibling relational problem
  - relational problem NOS

  Problems Related to Abuse or Neglect
  - physical abuse of child
  - sexual abuse of child
  - neglect of child

  . . .

  Additional Conditions that May Be a Focus of Clinical Attention

  . . .

  - child or adolescent antisocial behavior

  . . .

  - academic problem

For statistical (and payment) reporting purposes, assessments made using the DSM are assigned codes. For example, each of the categories listed above has a specific code assigned to it. Thus, if a youngster is diagnosed as attention-deficit hyperactivity disorder, combined type, the problem is assigned the code 314.01; if the diagnosis is conduct disorder, the code is 312.8. a special set of codes, called V codes, are used to identify individuals who have problems that require treatment but do not meet the criteria set for one of the disorders.

A summary diagnosis and coding might look like this:

Axis I	Conduct disorder -- adolescent onset (severe)	312 8
Axis II	No evident disorder	V71 09
Axis III	No apparent contribution	
Axis IV	Problems with educational setting	3
Axis V	Current functioning	GAF = 50

W. Paul Jones has written a useful little book for school staff interested in the DSM. He entitles the work: *Deciphering the Diagnostic Codes: A Guide for School Counselors* (1997, Corwin Press). In the work, he states that using the DSM really begins with the General Assessment of Functioning. That is, if the GAF is high, even if there are symptoms there is no disorder to diagnose. Axis IV is used to assess psychosocial facet, Axis III considers medical conditions, Axis II looks at persistent, cross-situational patterns of behavior or conditions that are related to symptoms. Finally, the primary focus of treatment is identified on Axis I.

Some Cautions

(1) *Diagnoses must be based on formal criteria and professional assessment.*

Because so many terms used in formal classification schemes such as the DSM have found their way into everyday language, the words often are used without reference to formal criteria and without use of related professional assessment. For example, it is easy to fall into the trap of referring to common learning problems as learning disabilities, very active children as hyperactive or ADHD, commonplace anxieties as anxiety disorders, and sadness as depression or a mood disorder. *Use of formal diagnostic categories requires careful application of designated criteria as operationalized in formal assessments.* Such criteria have an inclusionary and exclusionary focus to facilitate differential diagnosis and are concerned with severity, pervasiveness, onset, and duration in determining whether there is a clinically significant impairment. They also stress ways of determining whether symptoms are substance -induced (through use of alcohol and others drugs/medications or as a result of toxin exposure) and what should be considered in determining whether symptoms are the result of a general medical condition.

(2) *Diagnoses should not be based on ensuring reimbursement from third-party payers.*

In his book, W. Paul Jones (cited above) recognizes the role that third-party payment for mental health services plays in the overdiagnosis of psychopathology by requiring identification of a disorder for reimbursement. He cautions "when, for example, a parent-child relation problem is identified on Axis I as the primary focus of treatment, there is a high probability that no third-party reimbursement will be available. If the provider can

find sufficient evidence to identify another disorder on Axis I, for example, anxiety, and then list the parent-child problem on Axis IV, the probability of eligibility for reimbursement by an insurer increases dramatically. ... until or unless third-party reimbursement becomes available before problems become severe, V codes will probably be reported on Axis I at a lower rate than codes that are eligible for reimbursement."

Two cautions discussed in the DSM-IV also should be noted:

(3) *DSM diagnostic criteria are only guidelines and not all conditions needing treatment are included.*

> "The specified diagnostic criteria for each mental disorder are offered as guidelines for making diagnoses ... to enhance agreement among clinicians and investigators. The proper use of these criteria requires specialized clinical training .... [The work reflects] a consensus of current formulations of evolving knowledge .... They do not encompass, however, all the conditions for which people may be treated...."

(4) *Watch out for cultural diversity.*

> "Diagnostic assessment can be especially challenging when a clinician from one ethnic or cultural group uses the DSM-IV Classification to evaluate an individual from a different ethnic or cultural group. A clinician who is unfamiliar with the nuances of an individual's cultural frame of reference may incorrectly judge as psychopathology those normal variations in behavior, belief, or experience that are particular to the individual's culture."

DSM and the International Classification of Diseases (ICD)

The *official* diagnostic classification and coding system in use in the U.S. is the *International Classification of Diseases*, 9th Revision, Clinical Modification (ICD-9-CM). Under development is the *International Statistical Classification of Diseases and Related Health Problems*, 10th Revision (ICD-10) -- developed by the World Health Organization (WHO). The U.S. Department of Health and Human Services plans to require use of ICD-10 codes for reporting purposes throughout the U.S. (probably around the turn of this century). The DSM notes that to facilitate the transition, "preparation of DSM-IV has been closely coordinated with the preparation of Chapter V, 'Mental and Behavioral Disorders,' of ICD-10 . . . ." so that the respective codes and terms are fully compatible. Appendix H in the DSM-IV provides a cross-translation.

Examples of Some Tools Contained in the Accompanying Materials

A Form to Request Assistance in Addressing Concerns About a Student/Family

A Structured Outline for Exploring the Problem with the Student/Family
(Outlining specific areas and topics that might be explored to better understand the nature and scope of problems)

A Suicidal Assessment Checklist

Request for Assistance in Addressing Concerns about a Student/Family

Extensive assessment is not necessary in initially identifying a student about whom you are concerned. Use this form if a student is having a *significant* learning problem, a *major* behavior problem, or seems *extremely* disturbed or disabled.

Student's Name _____ Date:_____

To: _____ Title: _____

From: _____ Title: _____

Apparent problem (check all that apply):

___ physical health problem (specify) _____

___ difficulty in making a transition
( ) newcomer having trouble with school adjustment ( ) trouble adjusting to new program

___ social problems
( ) aggressive ( ) shy ( ) overactive ( ) other _____

___achievement problems
( ) poor grades ( ) poor skills ( ) low motivation ( ) other _____

___ major psychosocial or mental health concern

( ) drug/alcoh. abuse	( ) pregnancy prevention/support	( ) self esteem
( ) depression/suicide	( ) eating problems (anorexia, bulim.)	( ) relationship problems
( ) grief	( ) physical/sexual abuse	( ) anxiety/phobia
( ) dropout prevention	( ) neglect	( ) disabilities
( ) gang involvement	( ) reactions to chronic illness	

Other specific concerns

Current school functioning and desire for assistance

Overall academic performance
( ) above grade level ( ) at grade level ( ) slightly below grade level ( ) well below grade level

Absent from school
( ) less than once/month ( ) once/month ( ) 2-3 times/ month ( ) 4 or more times/month

Has the student/family asked for:

information about service	Y	N
an appointment to initiate help	Y	N
someone to contact them to offer help	Y	N

If you have information about the cause of a problem or other important factors related to the situation, briefly note the specifics here (use the back of the sheet if necessary).

Exploring the Problem with the Student/Family

The following general guide is meant to provide an overview of the types of information you might pursue in order to learn a bit more about a student's problem.

In general, you will want to explore

What's *going well*?

What's *not going so well* and *how pervasive and serious* are the problems?

What seems to be the *causes* of the problems?

What's *already been tried* to correct the problems?

What *should be done* to make things better?

(What does the student/family think should be done? Do the causes shed any light on what needs to be done? Does what's already been tried shed any light? What are the student/family willing to try? How much do they truly think that things can be made better?)

The following pages outline specific areas and topics that might be explored in understanding the nature and scope of the problem(s). This is followed by a few examples of the many tools that are available to structure interviews.

Obviously, in a brief session, only a limited amount of information can be gathered. Choices must be made based upon your understanding of the problem(s) identified and the population you serve.

Remember, if you are going to do a formal interview with a student about psychosocial/mental health concerns, you usually will need both a signed informed consent from a parent or legal guardian. And, even if it is required, it is good practice to get the student's assent as well.*

*Your school may want to obtain a copy of the introductory packet on *Confidentiality and Informed Consent* -- available from the Center for Mental Health in Schools at UCLA.

Outline of Specific Areas and Topics that Might be Explored to Better Understand the Nature and Scope of Problems

To explore what's going well and what's not, you will want to ask about current status related to various aspects of a student's daily life. To this end, Henry Berman, MD, proposes an approach to interviewing that he calls HEADS (**H**ome, **E**ducation, **A**ctivities, **D**rugs, and **S**exuality). This acronym is meant to guide the interviewer in exploring key facets of a young person's life, especially those that may be a source of trouble.

Borrowing and adding to this framework, the following areas and topics might be explored with respect to current status. *Where problems are identified, past circumstances related to the area and topic can be further discussed to help clarify duration, possible causes, and past or current efforts to deal with them.*

Home & Health?

Place of residence?

Where does the student live and with whom?
Physical conditions and arrangements in the residence?
Family status, relationships, and problems? (separation, loss, conflict, abuse, lack of supervision and care, neglect, victimization, alienation)

Physical health?

Developmental problems?
Somatic complaints?
accident proneness?
Indications of physical or sexual abuse?
Indications of eating problems?
Recent physical injury/trauma?

Emotional health?

Anxieties?
Fears?
Frustration?
Anger?
Frequent and extreme mood swings?
Self-image? (degree of: perceived sense of competence/efficacy; sense of worth; feelings of personal control over daily events; feelings of dependency on others; gender concern; self-acceptance; defensiveness)
Isolation or recent loss?
Hopes and expectations for the future?
If unhappy, is s/he depressed?
If depressed, is s/he suicidal?
psychic trauma?
symptoms of mental illness? (hallucinations, delusions)

Education?

School functioning?
- School attended, grade, special placement?
- Learning? (level of skills)
- Performance? (daily effort and functioning, grades)
- Motivation? (interests, attendance)

Relationships at school?
- Behavior? (cooperation and responsiveness to demands and limits)
- Special relationships with any school staff? (anyone really liked or hated)

Plans for future education and vocation?

Activities?

Types of interests? (music, art, sports, religion, culture, gang membership)

Responsibilities? (caring for siblings, chores, job)

Relationships with peers?
- Any close friends?
- Separation/loss?
- Conflict?
- Abuse?
- Neglect?
- Victimization?
- Alienation?

Relationships with other adults?

Involvement with the law?

How individual usually spends time?

Drugs?

Substance use? abuse?

Sexuality?

Active sexually? (informed about pregnancy and STD prevention?)

Considering becoming active sexually?

Is, has been, or currently wants to be pregnant?

You will also want to use the contact to **observe** aspects of the student/family that can shed additional light on these matters. These include

Appearance: dress, grooming, unusual physical characteristics

Behavior: activity level, mannerisms, eye contact, manner of relating to parent/therapist, motor behavior, aggression, impulsivity

Expressive Speech: fluency, pressure, impediment, volume

Thought Content: fears, worries preoccupations, obsessions, delusions, hallucinations

Thought Process: attention, concentration, distractibility, magical thinking, coherency of associations, flight of ideas, rumination, defenses (e.g., planning)

Cognition: orientation, vocabulary, abstraction, intelligence

Mood/Affect: depression, agitation, anxiety, hostility absent or unvarying; irritability

Suicidality/Homicidality: thoughts, behavior, stated intent, risks to self or others

Attitude/Insight/Strengths: adaptive capacity, strengths and assets, cooperation, insight, judgement, motivation for treatment

In assessing possibilities and motivation for addressing problems, you will want to explore

- desirable and desired, long-terms outcomes
- barriers that may interfere with reaching such outcomes
- immediate needs and objectives for intervention.

And you will want to clarify the student's, parents', and school's role in the process, and any other assistance that is needed, feasible, and desired.

SUICIDAL ASSESSMENT -- CHECKLIST*

Student's Name:_____ Date:_____ Interviewer: _____

(Suggested points to cover with student/parent)

(1) PAST ATTEMPTS, CURRENT PLANS, AND VIEW OF DEATH

Does the individual have frequent suicidal thoughts? Y N

Have there been suicide attempts by the student or significant others in his or her life? Y N

Does the student have a detailed, feasible plan? Y N

Has s/he made special arrangements as giving away prized possessions? Y N

Does the student fantasize about suicide as a way to make others feel guilty or as a way to get to a happier afterlife? Y N

(2) REACTIONS TO PRECIPITATING EVENTS

Is the student experiencing severe psychological distress? Y N

Have there been major changes in recent behavior along with negative feelings and thoughts? Y N

(Such changes often are related to recent loss or threat of loss of significant others or of positive status and opportunity. They also may stem from sexual, physical, or substance abuse. Negative feelings and thoughts often are expressions of a sense of extreme loss, abandonment, failure, sadness, hopelessness, guilt, and sometimes inwardly directed anger.)

(3) PSYCHOSOCIAL SUPPORT

Is there a lack of a significant other to help the student survive? Y N

Does the student feel alienated? Y N

(4) HISTORY OF RISK-TAKING BEHAVIOR

Does the student take life-threatening risks or display poor impulse control? Y N

*Use this checklist as an exploratory guide with students about whom you are concerned. Each yes raises the level of risk, but there is no single score indicating high risk. A history of suicide attempts, of course, is a sufficient reason for action. High risk also is associated with very detailed plans (when, where, how) that specify a lethal and readily available method, a specific time, and a location where it is unlikely the act would be disrupted. Further high risk indicators include the student having made final arrangements and information about a critical, recent loss. Because of the informal nature of this type assessment, it should not be filed as part of a student's regular school records.

BEST COPY AVAILABLE

Test Questions -- Unit II: Section A

(1) Which of the following were discussed as major facets of identifying and processing students in need of assistance for mental health and psychosocial problems?

___(a) initial problem identification
___(b) screening/assessment
___(c) client consultation and referral
___(d) triage
___(e) initial case monitoring
___(f) a, b, d
___(g) a, b, e
___(h) all the above

(2) It is especially hard to know the underlying cause of a problem when a student is not very motivated to learn and perform at school

___True ___False

(3) Screening can be used to help clarify the nature, extent, and severity of a problem?

___True ___False

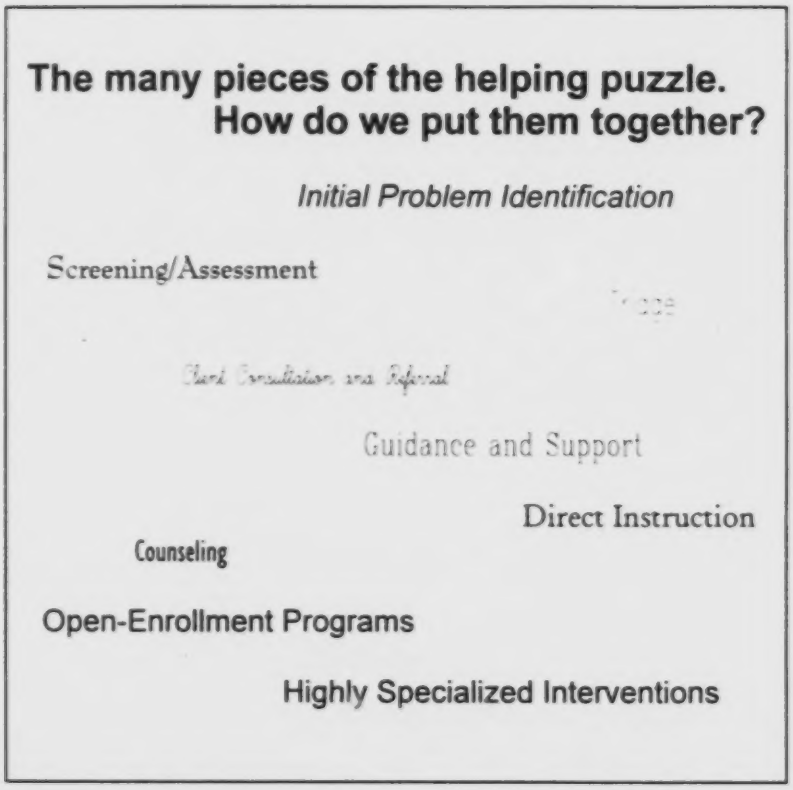
(4) The instrument for screening suicidal risk doesn't ask about

___(a) past attempts, current plans, and view of death
___(b) reactions to precipitating events
___(c) available psychosocial support
___(d) attitudes toward school
___(e) history of risk-taking behavior

(5) Which of the following are a focus of the initial interview/questionnaire instruments

___(a) the student's perception of the problem
___(b) what has been tried previously to deal with the problem
___(c) motivation to do something about the problem
___(d) a, b
___(e) all the above

Section B: Problem Response and Prevention



Contents:

Psychological First Aid: Responding to a Student in Crisis
Primary Prevention and Treatment
- Mental Health Education
- Psychosocial Guidance and Support
- Psychosocial Counseling

Ongoing Case Monitoring
To Review

BEST COPY AVAILABLE

Objectives for Section B

After completing this section of Unit II, you should be able to:

- explain the immediate objective of psychological first aid.
- identify three phases of crisis intervention
- identify seven activities related to providing psychosocial guidance and support
- identify at least 5 specific things that can be done to facilitate student communication in a psychosocial counseling situation

A Few Focusing Questions

- *Besides providing immediate psychological first aid, what other concerns arise during crisis intervention?*
- *What is the potential scope of mental health education in schools?*
- *What can a school do to provide additional guidance and support related to psychosocial concerns?*
- *How does one develop a psychosocial counseling relationship with a student?*
- *What is involved in providing ongoing case monitoring?*
- *What does the term informed consent really mean?*
- *What due process rights do parents have?*
- *When are the major exceptions to ensuring a student that what is said in counseling will be kept confidential?*

Psychological First Aid: Responding to a Student In Crisis

David Schonfeld, Marsha Kline, and their colleagues at Yale University note:

> Schools are no longer the "islands of safety" that they once were believed to represent, as street crime, random violence, and large-scale accidents pervade schools in all parts of the country and affect children of all ages on a regular basis . . . . In a survey conducted in 1978 in two public high schools in Kansas City, Kansas, nearly 90% of the students reported having experienced the death of a grandparent, aunt, uncle, sibling, or someone else they cared about, 40% of the students reported the death of a close friend of their, own age, and approximately 20% had witnessed a death. In a 1990 survey involving urban high school students, half the students reported that they knew someone who had been murdered, 37% had witnessed a shooting, and 31%, a stabbing (Pastore *et al.*, 1991). In another survey of students attending 10 inner-city high schools, rates of direct gun-related victimization were alarmingly high; 20% of the students reported having been threatened with a gun and 12% had been the target of a shooting (Sheley *et al.*, 1992). The exposure to community violence and violent deaths is not restricted to adolescents and adults .... In a 1992 study conducted in an. urban pediatric continuity clinic in Boston, 7% of the children had witnessed a shooting or stabbing before the age of 6 years . . . . As schools face an escalating number of crises, the probability that any child or group of children will experience violence or sudden death of a friend and/or loved one is increasing.
>
> These events often require a response from the school in order to address the children's developmental needs during times of crisis and uncertainty. These crisis periods can disrupt learning, at a minimum, and also have the potential to retard children's emotional and psychological adjustment to the event and impair their subsequent development.
>
> Despite the overwhelming need for a crisis prevention and response plan, many schools remain unprepared. . . . School systems, therefore, need to develop and institute a coordinated and systematic response plan before another crisis occurs. School systems, however, may be reluctant to consider the potential for crises to occur and may deny the need for crisis intervention services . . . . This organizational denial of the need for crisis intervention services may also be reflected in an organizational push to resolve a crisis prematurely -- "to get things back to normal as soon as possible." . . . . Schools increasingly need an effective crisis prevention and response plan in order to avert disasters where possible and to ameliorate their impact on children when the disasters cannot be avoided . . . .

Pynoos and Nader (1988) discuss psychological first aid for use during and in the immediate aftermath of a crisis (providing a detailed outline of steps according to age). Their work helps all of us think about some general points about responding to a student who is emotionally upset.

Psychological first aid for students/staff/parents can be as important as medical aid. The immediate objective is to help individuals deal with the troubling psychological reactions.

(1) Managing the situation

A student who is upset can produce a form of *emotional contagion*.

To counter this, staff must

- present a calm, reassuring demeanor
- clarify for classmates and others that the student is upset
- if possible indicate why (correct rumors and distorted information)
- state what can and will be done to help the student.

(2) Mobilizing Support

The student needs *support and guidance*.

Ways in which staff can help are to

- try to engage the student in a problem-solving dialogue
  >normalize the reaction as much as feasible
  >facilitate emotional expression (e.g., through use of empathy, warmth, and genuineness)
  >facilitate cognitive understanding by providing information
  >facilitate personal action by the student
  (e.g., help the individual do something to reduce the emotional upset and minimize threats to competence, self-determination, and relatedness)
- encourage the student's buddies to provide social support
- contact the student's home to discuss what's wrong and what to do
- refer the student to a specific counseling resource.

(3) Following-up

Over the following days (sometimes longer), it is important to check on how things are progressing.

- Has the student gotten the necessary support and guidance?
- Does the student need help in connecting with a referral resource?
- Is the student feeling better? If not, what additional support is needed and how can you help make certain that the student receives it?

Another form of "first aid" involves helping needy students and families connect with emergency services. This includes connecting with agencies that can provide emergency food, clothing, housing, transportation, and so forth. Such basic needs constitute major crises for too many students and are fundamental barriers to learning and performing and even to getting to school.

STOP. THINK. DISCUSS

A teacher brings you the following piece written by a student in class.

I am 13 yeers old and learning
disabled I have had problems along time
People say I am smart but I lak eny
ability and I am tired of tryins.
My parrents tryed to help me,
but I dont deserve there supp ort
or concern, I am just not worth
it. I do not get allong with
people eneywhere and never have bren
able to. I am affraid of everyone
and hate being told to wake up
or come out of my dreemworld
I dont know how to deel with
eneything eneywhere.

What do you think should be done?

BEST COPY AVAILABLE

A Few General Principles Related to Responding to Crises

Immediate Response -- Focused on Restoring Equilibrium

In responding:

- Be calm, direct, informative, authoritative, nurturing, and problem-solving oriented.
- Counter denial, by encouraging students to deal with facts of the event; give accurate information and explanations of what happened and what to expect -- never give unrealistic or false assurances.
- Talk with students about their emotional reactions and encourage them to deal with such reactions as another facet of countering denial and other defenses that interfere with restoring equilibrium.
- Convey a sense hope and positive expectation -- that while crises change things, there are ways to deal with the impact.

Move the Student from Victim to Actor

- Plan with the student promising, realistic, and appropriate actions they will pursue when they leave you.
- Build on coping strategies the student has displayed.
- If feasible, involve the student in assisting with efforts to restore equilibrium.

Connect the Student with Immediate Social Support

- Peer buddies, other staff, family -- to provide immediate support, guidance, and other forms of immediate assistance.

Take Care of the Caretakers

- Be certain that support systems are in place for staff in general
- Be certain that support (debriefing) systems are in place for all crisis response personnel.

Provide for Aftermath Interventions

- Be certain that individuals needing follow-up assistance receive it.

REFLECTIONS ON CRISIS COUNSELING

When I first joined the crisis team, I thought we'd usually be dealing with emergencies that disrupted the whole school. But, most of the emergencies have involved individual students who seem suicidal or have taken a drug overdose, and most of the aftermath counseling has involved small groups of students and staff who are affected by the death of a student or staff member.

In times of crisis, I often have felt overwhelmed by the depth of despair and grief experienced by so many. In reaching out, I have had to learn how to draw in those among the quiet ones who will let some of it out only if I encourage turn-taking during an aftermath group session.

I also have learned how to avoid overwhelming those who are not ready, psychologically, to deal with what happened and those for whom the event itself is not important except as a trigger setting off strong emotions (e.g., pent up grief related to the death of others who were close to them and/or fears about their own mortality). At the same time, I've learned to avoid playing into the dynamics of those who just seem to get caught up in and want to maintain the supercharged atmosphere created by a crisis.

Early in my crisis team experience, I was surprised when one administrator seemed reluctant to have the team offer aftermath support. He wanted things to return to 'normal' as fast as possible and was convinced the team's activity would keep things stirred up. He also expressed concern that many students would be overwhelmed by the added pressures of reflecting on what had happened, listening to others' reactions, and expressing their own. He had concluded that the best strategy was to encourage everyone to put the event behind them and get on with things. We agreed that he was probably right with respect to most students. And, we finally convinced him that we could proceed in ways that would help to normalize the situation for the majority and still provide for those with special needs.

I have since learned that many people share a concern that crisis interveners don't appreciate how many individuals are ready to get on with things. So, I always try to assure everyone that I understand this, and then I clarify that helping those with special needs is an important part of getting things back to normal.

(cont.)

REFLECTIONS ON CRISIS COUNSELING (cont).

A specific aspect of normalization after the death of a student or staff member seems to be a wide-spread desire to gather funds to help the family if there is a need and or to arrange a tribute. When this is the case, the concerned energy of most of the school population can be channeled in this direction after initial expressions of emotion are validated. Extended aftermath groups are necessary only for those seen as profoundly affected.

One of the hardest things about crisis counseling is establishing a relationship with students who don't know me at a time when they desperately need someone familiar whom they can trust. Therefore, I try, whenever possible, to enlist someone to work beside me who the students look up to. At the very least, I quickly identify someone in the group with whom I can ally myself.

Responding to crisis is exhausting. Thus, we have found it essential to have enough team members to spell each other whenever extended counseling is required on a given day. In responding to the needs of others, it is easy to ignore the impact on ourselves.

As a health professional, what drew me to crisis intervention is that I knew it was an essential element of any comprehensive approach to maintaining psychological well-being. What I didn't realize was what a powerful contribution an active school-based crisis team could make to a school's sense of community. At first, team meetings focused on improving crisis response plans and communicating them to the rest of the school. We found our efforts to take care of these matters were reassuring to others. Once these tasks were accomplished, we found ourselves addressing other school safety concerns and ways for students and staff to be more supportive of each other. In many ways, the crisis team has become a special forum for sharing concerns and a symbol of the school community's commitment to taking care of each other. And, I think that is pretty basic to maintaining our mental health!

Note: As a follow-up aid for you and your school, included in the accompanying materials is a resource packet entitled *Responding to Crisis at a School* -- prepared by the Center for Mental health in Schools at UCLA. Also, see the cited articles:

Schonfeld, Kline, et al. (1994), School-based crisis intervention: An organizational model. *Crisis Intervention, 1*, 155-166;

Pynoos & Nader (1988), Psychological first aid and treatment approach to children exposed to community violence. *Journal of Traumatic Stress, 1*, 445-473.

Primary Prevention and Treatment

As already noted, many school staff can and want to be more involved in programs to prevent and correct mental health and psychosocial problems. Among the functions some already are carrying out are

(1) mental health education

(2) psychosocial guidance and support

(3) psychosocial counseling

(1) *Mental Health Education*

Educative functions range from disseminating mental health information to actual course instruction related to positive social and emotional development and wellness.

Every school needs to disseminate information that helps protect, promote, and maintain the well-being of students with respect to both physical but mental health. School staff already play a major role in disseminating health related information. It does not take much imagination to see how important it is that such activity encompass mental health. This includes providing highly visible information related to prevention and correction:

- positive opportunities for recreation and enrichment
- opportunities to earn money
- how to stay healthy -- physically and mentally (this includes instruction using curricula on special topics such as social skills and interpersonal relationships, substance abuse, violence prevention, physical and sexual abuse prevention, sex education, and so forth)
- early identification of problems
- what a student/parents should do when problems arise
- warm lines and hotlines
- services on- and off-campus.

During the instructional day, the curricula in many classes touches upon matters related to positive social and emotional development and wellness. In addition, some schools actually have incorporated mental health as a major facet of health education. And school staff are involved each day in dealing with matters related to mental health and psychosocial concerns.

> Related to these matters, efforts should be made to capitalize on the strengths of school staff by facilitating ways for them to play a role with students as part of a school's efforts to provide comprehensive physical and mental health education and by participating in developing the capacity of other staff to address these matters.

In addition, a wide variety of staff can play a role in a variety of open-enrollment programs designed to foster positive mental health and socio-emotional functioning. They can also help establish strategies to change the school environment in ways that make it more inviting and accommodating to students. This involves participation in staff development, but even more, it requires working with school staff to restructure the school so that it effectively promotes a sense of community. Examples include establishing welcoming programs for new students and families and strategies to support other transitions, developing *families* of students and teachers to create schools within schools, and teaching peers and volunteer adults to provide support and mentoring. Intervening at this environmental level also encompasses working with community agencies and businesses to enhance the range of opportunities students have with respect to recreation, work, and community service.

> Effective open-enrollment and prereferral intervention programs and environment change strategies can minimize the number of mild to moderate problems that develop into severe ones. This reduces the number in need of specialized interventions and helps reserve such help for those who inevitably require them.

Note: As a follow-up aid for you and your school, included in the accompanying materials is a resource packet entitled *Where to Get Resource Materials* -- prepared by the Center for Mental health in Schools at UCLA. This packet provides references to sources for materials, curricula, fact sheets (see example at end of this section), and various other forms of assistance for mental health education.

(2) *Psychosocial Guidance and Support*

Each day many students require a small dose of personalized guidance and support to enhance their motivation and capability for coping with stressors. Others who are involved in therapeutic treatment (e.g., personal counseling, psychotherapy, psychotropic medication) need someone who understands the treatment and can deal with related concerns that arise at school.

> Personalized guidance and support is best provided on a regular basis in the classroom and at home. There are great benefits to be gained from any role others may play in (a) helping teachers function in ways where they directly provide such support or do so through use of various activities and peer support strategies and (b) mobilizing and enhancing support from those in the home.

Specialist staff also are logical persons for a student to contact if something is amiss between what is happening at school and the student's therapeutic regimen. And they are good resources to interface with a student's personal counselor or therapist and to act as a school-site case manager so that there is coordination between the school's efforts to teach and any treatment the student is receiving.

Guidance and support involves a range of potential activity:

- advising
- advocacy and protection
- providing support for transitions (e.g., orienting new students and connecting them with social support networks, facilitating students with special needs as they transition to and from programs and services)
- mediation and conflict resolution
- promoting and fostering opportunities for social and emotional development
- being a liaison between school and home.
- being a liaison between school and other professionals serving a student

Note: Special considerations and concerns arise related to students taking psychotropic medications. As a follow-up aid for you and your school, included in the accompanying materials is a resource packet on this topic entitled *Students and Psychotropic Medication: The School's Role* -- prepared by the Center for Mental health in Schools at UCLA.

(3) *Psychosocial Counseling*

Some student's problems will be more than you should try to handle and you will make the best effort you can to connect them with the right help.

> There are many, however, who could benefit from your counseling -- once you have equipped yourself for the task and if you can create the time.

Good counseling builds on the type of caring which is fundamental to all helping relationships. It also encompasses the basics of any good working relationship -- and a bit more. Some basics are highlighted here. You will want to learn more and a good next step is to read some of the works referenced at the end of this unit.

> In general, counseling requires the ability to carry on a *productive dialogue*, that is, to talk with, not at, others. This begins with the ability to be an active (good) listener and to avoid prying and being judgmental. It also involves knowing when to share information and relate one's own experiences as appropriate and needed. Some thoughts about engaging students in a productive dialogue are outlined on the following pages.

Counseling also requires the ability to create a working relationship that quickly conveys to the student

- *positive value and expectation* (that something of value can and will be gained from the experience)
- *personal credibility* (that the counselor is someone who can help and can be trusted to be keep his or her word, be fair, and be consistent, yet flexible)
- *permission and protection to engage in exploration and change* (that the situation is one where there are clear guidelines saying it is okay and safe to say what's on one's mind).

All this enables the counselor to elicit a student's concerns.

Then, the process requires the ability to respond with

- *empathy, warmth, and nurturance* (e.g., the ability to understand and appreciate what others are thinking and feeling, transmit a sense of liking, express appropriate reassurance and praise, minimize criticism and confrontation)

- *genuine regard and respect* (e.g., the ability to transmit real interest, acceptance, and validation of the other's feelings and to interact in a way that enables others to maintain a feeling of integrity and personal control).

STOP. THINK. DISCUSS

Think about the students you have found it easy to talk with.

What made the dialogue go so well?

Think about those students you found it difficult to engage in a dialogue.

What are some ideas that might help next time you encounter such a student?

A Few Thoughts About Engaging Students in a Productive Dialogue

A few are so nonverbal that referral probably is indicated. Many, however, are just reluctant to talk.

How to Facilitate "Talk"

Quite often, one has to start building a relationship around relatively nonverbal activities, such as responding to a structured set of interview questions dealing with common concerns. In some cases, having students draw themselves or significant others and telling a story about the picture can break the ice and provide some leads.

In general, the focus is on enhancing motivational readiness to dialogue by creating a sense of positive value and expectation for counseling, personal credibility for the counselor, and permission and protection for engaging in exploration for change.

Some specific things to do are

Create a private space and a climate where the student can feel it is safe to talk

Clarify the role and value of keeping things confidential

Avoid interruptions

Start slowly, avoid asking questions, and minimize pressure to talk (the emphasis should be more on conversation and less on questioning and on nonsensitive topics related to the student's main areas of personal interest)

Encourage the student to take the lead

Humor can open a dialogue; sarcasm usually has the opposite effect

Listen with interest

Respond with empathy, warmth, nurturance, and genuine regard and respect

Use indirect leading statement such as "Please tell me more about ...." or direct leading statements such as "You said that you were angry at your parents?"

If needed, use structured tools (surveys, sentence completion) to guide a student
(Examples of tools that may be useful are included in the accompanying materials resource packet entitled Screening/Assessing Students: Indicators and Tools.)

Sometimes a list of items (e.g., things that students generally like and dislike at school or after school) can help elicit a student's views and open-up a dialogue

When questions are asked, use open-ended, rather than yes/no questions

Appropriate self-disclosure by a counselor may disinhibit a reluctant student

In addition, for groups

Facilitate sharing through various activities (pairing a reluctant student with a supportive peer, having the group share backgrounds)

Clarify that trust, respect, confidentiality, etc. are a function of commitment to the group -- not a matter of stating rules

How to Keep Talk Going

In general, the focus is on maintaining motivation.

Some specific things to do are

- Focus on areas of interest, strength, and self-esteem, as well as on analyzing problems
- Build on previous discussions by referring to what has been shared
- Continue to follow student's leads in analyzing problems and avoid procedures they may perceive as efforts to control them
- Continue to convey that the intent is to help not socialize

In addition, for groups

- Draw out similarities in experience and problems with a view to encouraging students to see the value of helping each other
- Help students understand that giving advice usually is ineffective

Remember:

- Short periods of silence are part of the process and should be accommodated.

A group of adolescents agreed to advise
school and community professionals
on what they and peers needed
in order to feel helped.
The most basic thing they stressed was:
"Let us talk about the things
that are really happening
in our lives -- friends, sex, drugs."
"We need people in schools
who care and will listen."

Some Points About Counseling and Student Motivation

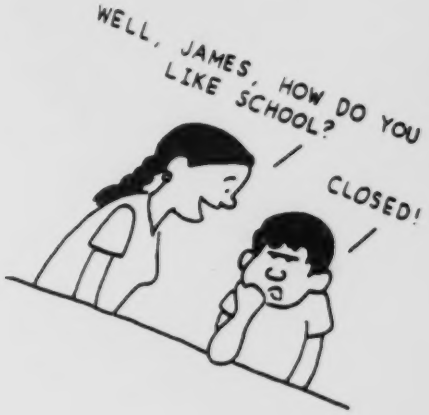
Most counseling at a school site is short-term. Some will be informal -- brief encounters with students who drop-in or are encountered somewhere on campus. All encounters have the potential to be productive as long as one attends to student motivation as key antecedent and process conditions and as an important outcome concern.

(1) **Motivation is a key antecedent condition.** That is, it is a prerequisite to functioning. Poor motivational readiness may be (a) a cause of inadequate and problem functioning, (b) a factor maintaining such problems, or (c) both. Thus, strategies are called for that can result in enhanced motivational readiness (including reduction of avoidance motivation) -- so that the student we are trying to help is mobilized to participate.

(2) **Motivation is a key ongoing process concern.** Processes must elicit, enhance, and maintain motivation -- so that the student we are trying to help stays mobilized. For instance, a student may value a hoped for outcome but may get bored with the processes we tend to use.

With respect to both readiness and ongoing motivation, conditions likely to lead to negative motivation and avoidance reactions must be avoided or at least minimized. Of particular concern are activities students perceives as unchallenging/ uninteresting, overdemanding, or overwhelming and a structure that seriously limits their range of options or that is overcontrolling and coercive. Examples of conditions that can have a negative impact on a student's motivation are excessive rules, criticism, and confrontation.

(3) **Enhancing intrinsic motivation is a basic outcome concern.** A student may be motivated to work on a problem during counseling but not elsewhere. Responding to this concern requires strategies to enhance stable, positive attitudes that mobilize the student to act outside the intervention context and after the intervention is terminated.



Essentially, good counseling reflects the old maxim of "starting where the student is." But more is involved than matching the student's current capabilities. As suggested, attending to a student's motivational levels is also critical. Thus, it is the counselor's responsibility to create a process that will be a good fit with the student's capabilities *and* motivation.

> The less one understands the background and experiences that have shaped a student, the harder it may be to create a good fit. This problem is at the root of concerns about working with students who come from different cultures. It is, of course, a concern that arises around a host of individual differences.

As discussed in the unit on working with others, efforts to create effective working relationships require a breadth and depth of knowledge, skills, and positive attitudes.

Counseling aims at enabling students to increase their sense of competence, personal control, and self-direction -- all with a view to enhancing ability to relate better to others and perform better at school. When a counseling relationship is established with a student, care must be taken not to undermine these aims by allowing the student to become dependent and overrely on you. Ways to minimize such dependency include

- giving advice rarely, if at all
- ensuring that the student takes personal responsibility for her or his efforts to deal with problems and assumes credit for progress
- ensuring that the student doesn't misinterpret your efforts to help or lose sight of the limits on your relationship
- helping the student identify when it is appropriate to seek support and clarifying a wide range of ways to do so.
- planning a careful transition for termination

And be sure to avoid the "Rescue Trap."

The Rescue Trap

So you want to help! That's a nice attitude, but it can sometimes lead to trouble -- especially if you aren't aware of the interpersonal dynamics that can arise in helping relationships. Several concerns have been discussed in the psychotherapy literature. One that almost everyone has experienced has been described as a "rescue."

A *rescue* is helping gone astray. Rescues encompass a cycle of negative interpersonal transactions that too commonly arise when one person sets out to intervene in another's life in order to help the person.

Think about a time when someone you know told you about a problem she or he was having. Because the person seemed not to know how to handle the problem, you offered some suggestions. For each idea you offered, the person had an excuse for why it wouldn't work. After a while, you started to feel frustrated and maybe even a bit angry at the person. You may have thought or said to the individual, "You don't really want to solve this problem; you just want to complain about it."

In rescue terms, you tried to help, but the person didn't work with you to solve the problem. The individual's failure to try may have frustrated you, and you felt angry and wanted to tell the person off. And that may only have been the beginning of a prolonged series of unpleasant interpersonal transactions related to the situation.

If you were ever in such a situation, you certainly experienced the price a person pays for assuming the role of rescuer. Of course, you know you didn't mean to become involved in a negative set of transactions. You wanted to help, but you didn't realize fast enough that the individual with the problem wasn't about to work with you in order to solve it. And you didn't know what to do when things started going wrong with the process.

If you can't remember a time you were the rescuer, you may recall a time when someone tried to rescue you. Perhaps your parents, a teacher, or a good friend made the mistake of trying to help you when or in ways you didn't want to be helped. The person probably thought she or he was acting in your best interests, but it only made you feel upset -- perhaps increased your anxiety, frustration, anger, and maybe even made you feel rather inadequate.

Rescue cycles occur frequently between teachers and students and parents and their children. Well-intentioned efforts to help usually begin to go astray because someone tries to help at a time, in a way, or toward an end the person to be helped doesn't experience as positive.

Let's take the example of a teacher, Ms. Benevolent, and one of her students, Jack. Ms. Benevolent is a new teacher who has just begun to work with a group of students with learning problems. She sees her students, Jack included, as handicapped individuals, and she wants so much to help them.

(cont.)

The Rescue Trap (cont.)

Unfortunately, Jack doesn't want to be helped at the moment. And when he doesn't want to be helped, Jack is not mobilized to work on solving his problems. Indeed, efforts to intervene often make him feel negative toward his teacher and even toward himself. For example, he may feel anger toward Ms. Benevolent and feel guilty and incompetent because of not working to solve his learning problem. Ironically, not only doesn't he see the teacher as a helper, he also feels victimized by her. In response to these feelings, he behaves in a self-protective and defensive manner. Sometimes he even assumes the stance of being a helpless victim. ("How can you expect me to do that? Don't you know I have a learning handicap?")

Because Jack continues to respond passively or in ways the teacher views as inappropriate, eventually she becomes upset and starts to react to him in nonhelpful and sometimes provocative ways. She may even have a tendency to subtly persecute Jack for not being appreciative of all her efforts to help him. ("You're just lazy." "If your attitude doesn't improve, I'm going to have to call your parents.")

The more the teacher pushes Jack to act differently and attacks him for acting (and feeling) as he does, the more likely he is to feel victimized. However, sooner or later he is likely to become angry enough about being victimized that he reacts and counterattacks. That is, if he can, he shifts from the role of victim to the role of persecutor.

When interveners who see themselves as benevolent helpers are attacked, they may tend to feel victimized. Indeed, the experience of having been unsuccessful in helping may be sufficient to make some interveners feel this way. As Jack shifts to a persecuting role, Ms. Benevolent adopts a victim role. ("After all I've done for you, how can you treat me this way?" "All I'm trying to do is help you.")

Of course, interveners are unlikely to remain victims for very long if they can help it. If they do, "burn out" may well occur.

Sometimes, after the fighting stops, the parties make up, and the intervener starts to see the other person's behavior as part of the individual's problems and tries once more to help. However, if great care is not taken, this just begins the whole cycle again.

How can the cycle be avoided or broken? One of the essential ingredients in a good helping relationship is a person who wants to be helped. Thus, it is necessary to be sure that the person is ready and willing to pursue the type of help that is being offered.

If the person is not ready and willing, interveners are left with only a few options. For one, the intervener can choose to give up trying to help. Or if it is essential that the individual be *forced* to do something about the problem, the intervener can adopt a socialization strategy. Or effort can be made to explore with the individual whether he or she wants to think about accepting some help. In effect, this last approach involves trying to establish motivational readiness.

Regardless of how long you have seen a student for counseling, if a relationship has been established, you will need to deal with *termination*. This involves discussing the fact that the counseling is coming to an end, exploring any anxiety the student has about this, and reassuring the student about how s/he can deal with subsequent problems.

If the student is being referred for more counseling, you will want to provide support for a smooth transition, including clarifying what you should share with the new counselor. (This is a good reason for keeping a confidential Chart Record on the student.)

If the student will not be receiving additional support, you will want to try to connect her or him with an appropriate support network to draw upon (e.g., staff, peers, family).

If feasible, extend an invitation asking the student to let you know periodically how things are going.

Finally, a cautionary note about taking care of your own mental health:

In schools, the end of a school year may result in many students leaving all at the same time. For the counselor, this may produce a major sense of loss that adds to the frustrations of the job and contributes to feeling "burnt out." Burn out is a problem for all school staff.*

*Your school may want to obtain a copy of the introductory packet on *Understanding and Minimizing Burn Out* -- available from the Center for Mental Health in Schools at UCLA.

Ongoing Case Monitoring

Remember that from the time a student is first identified as having a problem, someone should be monitoring/managing the case. The process encompasses a constant focus to evaluate the appropriateness and effectiveness of the various efforts. That is, case monitoring is the process of checking regularly to ensure that a student's needs are being met so that appropriate steps can be taken if they are not. Such monitoring continues until the student service needs are addressed. It takes the form of case management when there must be coordination among the efforts of others who are involved (e.g., other services and programs including the efforts of the classroom teacher and those at home).

Case monitoring involves follow-ups with interveners and students/ families. This can take a variety of formats (e.g., written communications, phone conversations, electronic communications).

All case monitoring and case management require a system of record keeping designed to maintain an up-to-date record on the status of the student as of the last contact and that reminds you when a contact should be made. An example of a form used to facilitate follow-up on referrals is included on the following page.

Note: Other forms you can use to facilitate the processes described in this section are contained in a resource packet entitled *School-Based Client Consultation, Referral, and Management of Care* which is part of the accompanying materials provided by the UCLA Center for Mental Health in School as follow-up aids for you and your school.

Form Used to Aid Follow-Up on Referral Follow-Through

The following form should be used in conjunction with a general calendar system (a "tickler" system) that alerts staff to students who are due for some follow-up activity.

Student's Name: _____ Today's Date:_____

DATES FOR FOLLOW-THROUGH MONITORING

Scheduled date for Immediate Follow up_____ (about 2 weeks after referral)

Scheduled date for Long-term *first* Follow up_____

Schedule for *Subsequent* Long-term Follow ups _____ _____ _____

I. Immediate Referral Follow up Information

Date of referral _____ Today's date_____
Immediate Follow up made by_____ Date_____
_____ Date_____
_____ Date_____

Service Need	Agency (name and address)	Phone	Contact person	Appt. time

A. Put a check mark next to those agencies with which contact was made;
B. Put a line through agencies that didn't work out;
C. Put a circle next to agencies still to be contacted.

Indicate any new referrals recommended

Service Need	Agency (name and address)	Phone	Contact person	Appt. time

---

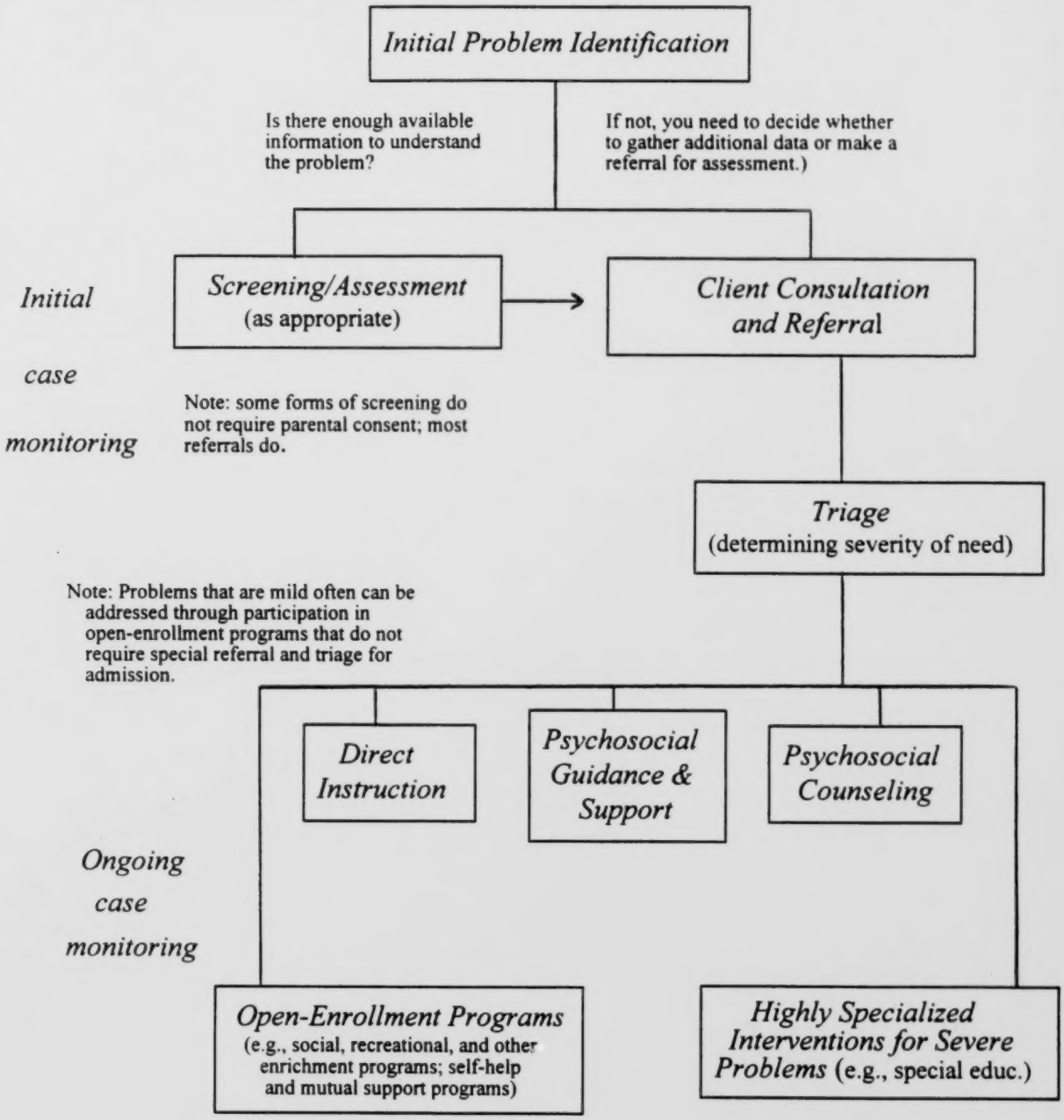
II. Long Term Referral Follow-Up Information

Have identified needs been met?

Contact the student at appropriate intervals (beginning three months after referral) and administer "Follow-up Interview Form -- Service Status."

To review:

In responding to the mental health and psychosocial concerns of students, school staff make a variety of decisions. The process begins when the problem comes to a staff member's attention.


Initial Problem Identification
Is there enough available information to understand the problem?
If not, you need to decide whether to gather additional data or make a referral for assessment.)
Initial case monitoring
Screening/Assessment (as appropriate)
Client Consultation and Referral
Note: some forms of screening do not require parental consent; most referrals do.
Triage (determining severity of need)
Note: Problems that are mild often can be addressed through participation in open-enrollment programs that do not require special referral and triage for admission.
Direct Instruction
Psychosocial Guidance & Support
Psychosocial Counseling
Ongoing case monitoring
Open-Enrollment Programs (e.g., social, recreational, and other enrichment programs; self-help and mutual support programs)
Highly Specialized Interventions for Severe Problems (e.g., special educ.)

On the following page is an outline of matters to be considered as a school develops its systems for problem identification, triage, referral, and case monitoring and management.

Matters for a School to Consider in Developing its Systems for Problem Identification, Triage, Referral, and Case Management

Problem identification

(a) Problems may be identified by anyone (staff, parent, student).
(b) There should be an Identification Form that anyone can access and fill out.
(c) There must be an easily accessible place for people to turn in forms.
(d) All stakeholders must be informed regarding the availability of forms, where to turn them in, and what will happen after they do so.

Triage processing

(a) Each day the submitted forms must be reviewed, sorted, and directed to appropriate resources by a designated and trained triage processor. Several individuals can share this task; for example, different persons can do it on a specific day or for specified weeks.
(b) After the sorting is done, the triage processor should send a Status Information Form to the person who identified the problem (assuming it was not a self-referral).

Clients directed to resources or for further problem analysis and recommendations

(a) For basic necessities of daily living (e.g., food, clothing, etc.), the triage processor should provide information about resources either through the person who identified the problem or directly to the student/family in need.
(b) If the problem requires a few sessions of immediate counseling to help a student/ family through a crisis, the triage processor should send the form to the person who makes assignments to on-site counselors.
(c) The forms for all others are directed to a small triage "team" (1-3 trained professionals) for further analysis and recommendations. (If there is a large case load, several teams might be put into operation.) Members of such a team may not have to meet on all cases; some could be reviewed independently with recommendations made and passed on the next reviewer for validation. In complex cases, however, not only might a team meeting be indicated, it may be necessary to gather more information from involved parties (e.g., teacher, parent, student).

Interventions to ensure recommendations and referrals are pursued appropriately

(a) In many cases, prereferral interventions should be recommended. This means a site must be equipped to implement and monitor the impact of such recommendations.
(b) When students/families are referred for health and social services, procedures should be established to facilitate motivation and ability for follow-through. Case management should be designed to determine follow-through, coordination, impact, and possible need for additional referrals.
(c) Referrals to assess the need for special or compensatory education often are delayed because of a waiting list. Back logs should be monitored and arrangements made to catch-up (e.g., by organizing enough released time to do the assessments and case reviews).

Case monitoring/management

(a) Some situations require only a limited form of case monitoring (e.g., to ensure follow-through). A system must be developed for assigning case monitors as needed. Aides and paraprofessionals often can be trained to for this function.
(b) Other situations require intensive management by specially trained professionals to (a) ensure interventions are coordinated/integrated and appropriate, (b) continue problem analysis and determine whether appropriate progress is made, (c) determine whether additional assistance is needed, and so forth. There are many models for intensive case management. For example, one common approach is to assign the responsibility to the professional who has the greatest involvement (or best relationship) with the student/family.
(c) One key and often neglected function of the case monitor/manager is to provide appropriate status updates to all parties who should be kept informed.

Examples of the Type of Facts Sheets that May be of Use in Your Work

Sample of a variety of fact sheets, descriptions of other related resources materials and mental health education curricula, and information on how to request the materials are included in an aid packet entitled Where to Get Resources (prepared by the Center for Mental Health in Schools at UCLA).

CARING FOR EVERY CHILD'S MENTAL HEALTH
Communities Together

FACT SHEET

Mental, Emotional, and Behavior Disorders in Children and Adolescents

The Center for Mental Health Services extends appreciation to the National Institute of Mental Health, which is part of the National Institutes of Health, for contributing to the preparation of this fact sheet. Any questions or comments about its contents may be directed to the CMHS National Mental Health Services Knowledge Exchange Network (KEN) — see contact information below.

Mental, Emotional, and Behavior Problems Are Real

Young people can have mental, emotional, and behavior problems that are real, painful, and costly. These problems, often called "disorders," are a source of stress for the child as well as the family, school, community, and larger society.

The number of families who are affected by mental, emotional, and behavior disorders in young people is staggering. It is estimated that as many as one in five children or adolescents may have a mental health problem that can be identified and treated. At least 1 in 20—or as many as 3 million young people—may have a "serious emotional disturbance."* This term refers to a mental health problem that severely disrupts a person's ability to function socially, academically, and emotionally.

Mental health disorders in children and adolescents are caused by biology, environment, or a mix of both. Examples of biological factors are genetics, chemical imbalances in the body, and damage to the central nervous system, such as a head injury. Many factors in a young person's environment can affect his or her mental health, such as exposure to violence, extreme stress, and loss of an important person.

Caring families and communities working together can help children and adolescents with mental disorders. A broad range of services often is necessary to meet the needs of these young people and families.

In this fact sheet, "Mental Health Problems" for children and adolescents refers to the range of all diagnosable emotional, behavioral, and mental disorders. They include depression, attention-deficit/hyperactivity disorder, and anxiety, conduct, and eating disorders, among others. Mental health problems affect one in every five young people at any given time.

"Serious Emotional Disturbances" for children and adolescents refers to the above disorders when they severely disrupt daily functioning in home, school, or community. Serious emotional disturbances affect 1 in every 20 young people at any given time.

The Disorders

Following are descriptions of some of the mental, emotional, and behavior problems that can occur during childhood and adolescence. All of these disorders can have a serious impact on a child's overall health.

**This fact sheet contains estimates of the prevalence (number of existing cases in a defined time period) of mental, emotional, and behavior disorders. These estimates are taken from several sources, most of which are small-scale studies that can yield only a rough gauge of prevalence rates. The National Institute of Mental Health is currently engaged in a nationwide study to determine with greater accuracy the prevalence of mental disorders among children and adolescents. This information is needed to increase understanding of mental health problems and to improve the treatment and services that help young people who are affected by these conditions.*

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration • Center for Mental Health Services
5600 Fishers Lane, Room 13-103 • Rockville, Maryland 20857 • Telephone 301 443 2792

CARING FOR EVERY CHILD'S MENTAL HEALTH: Communities Together Campaign

For information about children's mental health, contact the CMHS Knowledge Exchange Network
PO Box 42490 • Washington, DC 20015 • Toll-free 1 800 789 2647 • FAX 202 656 4012
FAX 301 984 8796 • TTY 301 443 9006 • CMHS Electronic Bulletin Board 1 800 790 2647

SAMHSA

BEST COPY AVAILABLE

Some disorders are more common than others, and conditions can range from mild to severe. Often, a child has more than one disorder.

Anxiety disorders are among the most common of childhood disorders. They affect an estimated 8 to 10 of every 100 children and adolescents. These young people experience excessive fear, worry, or uneasiness that interferes with their daily lives. Anxiety disorders include:

- **phobia** — an unrealistic and overwhelming fear of some object or situation;
- **generalized anxiety disorder** — a pattern of excessive, unrealistic worry not attributable to any recent experience;
- **panic disorder** — terrifying panic attacks that include physical symptoms such as rapid heartbeat and dizziness;
- **obsessive-compulsive disorder** — being trapped in a pattern of repeated thoughts and behaviors such as counting or handwashing; and
- **post-traumatic stress disorder** — a pattern of flashbacks and other symptoms that occurs in children who have experienced a psychologically distressing event such as physical or sexual abuse, being a victim or witness of violence, or exposure to some other traumatic event such as a bombing or hurricane.

Major depression is recognized more and more in young people. Years ago, many people believed that major depression did not occur in childhood. But we now know that the disorder can occur at any age. Studies show that up to 6 out of every 100 children may have depression. The disorder is marked by changes in:

- emotion — the child often feels sad, cries, looks tearful, feels worthless;
- motivation — schoolwork declines, the child shows no interest in play;
- physical well-being — there may be changes in appetite or sleep patterns and vague physical complaints; and
- thoughts — the child believes that he or she is ugly, that he or she is unable to do anything right, or that the world or life is hopeless.

Some adolescents or even elementary school children with depression may not place any value on their own lives, which may lead to suicide.

Bipolar disorder (manic-depressive illness) in children and adolescents is marked by exaggerated mood swings between extreme lows (depression) and highs (excitedness or manic phases). Periods of moderate mood occur in between. During a manic phase, the child or adolescent may talk nonstop, need very little sleep, and show unusually poor judgment. Bipolar mood swings can recur throughout life. Adults with bipolar disorder, as common as 1 in 100 adults, often experienced their first symptoms during teenage years.

Attention-deficit/hyperactivity disorder occurs in up to 5 of every 100 children. A young person with attention-deficit/hyperactivity disorder is unable to focus attention and is often impulsive and easily distracted. Most children with this disorder have great difficulty remaining still, taking turns, and keeping quiet. Symptoms must be evident in at least two settings (for instance, at home and at school) for attention-deficit/hyperactivity disorder to be diagnosed.

Learning disorders affect the ability of children and adolescents to receive or express information. These problems can show up as difficulties with spoken and written language, coordination, attention, or self-control. Such difficulties can make it harder for a child to learn to read, write, or do math. Approximately 5 of every 100 children in public schools are identified as having a learning disorder.

Conduct disorder causes children and adolescents to act out their feelings or impulses toward others in destructive ways. Young people with conduct disorder repeatedly violate the basic rights of others and the rules of society. The offenses that these children and adolescents commit often get more serious over time. Examples include lying, theft, aggression, truancy, firesetting, and vandalism. Children and adolescents with conduct

BEST COPY AVAILABLE

disorder usually have little care or concern for others. Current research has yielded varying estimates of the number of young people with this disorder; most estimates range from 4 to 10 of every 100 children and adolescents.

Eating disorders can be life threatening. A young person with **anorexia nervosa**, for example, cannot be persuaded to maintain a minimally normal body weight. This child or adolescent is intensely afraid of gaining weight and doesn't believe that he or she is underweight. Anorexia affects 1 in every 100 to 200 adolescent girls and a much smaller number of boys.

Youngsters with **bulimia nervosa** feel compelled to binge (eat huge amounts of food at a time). Afterward, to prevent weight gain, they rid their bodies of the food by vomiting, abusing laxatives, taking enemas, or exercising obsessively. Reported rates vary from 1 to 3 out of 100 young people.

Autism spectrum disorder or **autism** appears before a child's third birthday. Children with autism have problems interacting and communicating with others. They behave inappropriately, often repeating behaviors over long periods. For example, some children bang their heads, rock, or spin objects. The impairments range from mild to severe. Children with autistic disorder may have a very limited awareness of others and are at increased risk for other mental disorders. Studies suggest that autism spectrum disorder affects 7 to 14 of every 10,000 children.

Schizophrenia can be a devastating mental disorder. Young people with schizophrenia have psychotic periods when they may have hallucinations (sense things that do not exist, such as hearing voices), withdraw from others, and lose contact with reality. Other symptoms include delusional or disordered thoughts and an inability to experience pleasure. Schizophrenia is even more rare than autism in children under 12, but occurs in about 3 out of every 1000 adolescents.

Treatment, Support Services, and Research: Sources of Hope

Many of the symptoms and much of the distress associated with childhood and adolescent mental, emotional, and behavior problems may be alleviated with timely and appropriate treatment and support services.

A child or adolescent in need of treatment or services and his or her family may need a plan of care based on the severity and duration of symptoms. Optimally, this plan is developed with the family, service providers, and a service coordinator, who is referred to as a case manager. Whenever possible, the child or adolescent is involved in decisions.

> In a "System of Care," local organizations work in teams—with families as critical partners—to provide a full range of services to children and adolescents with serious emotional disturbances. The team strives to meet the unique needs of each young person and his or her family in or near their home. These services should also address and respect the culture and ethnicity of the people they serve. (For more information on systems of care, call 1.800.789.2647.)

Tying together all the various supports and services in a plan of care for a particular child and family is commonly referred to as a "system of care." A system of care is designed to improve the child's ability to function in all areas of life—at home, at school, and in the community. For a fact sheet on systems of care, call 1.800.789.2647.

Researchers are working to produce new knowledge and understanding about mental, emotional, and behavior disorders. Studies are also exploring ways to prevent and treat mental, emotional, and behavior problems, including the range of services that may be required.

Many of these studies are funded by Federal agencies within the Department of Health and Human Services, which include:

- the National Institutes of Health:
  - the National Institute of Mental Health
  - the National Institute of Child Health and Human Development
  - the National Institute for Drug Abuse

BEST COPY AVAILABLE

- the National Institute on Alcoholism and Alcohol Abuse.
- the Substance Abuse and Mental Health Services Administration:
  - the Center for Mental Health Services
  - the Center for Substance Abuse Prevention
  - the Center for Substance Abuse Treatment.
- the Administration for Children and Families
- the Health Resources and Services Administration.

Related activities are taking place within:

- the Department of Education
- the Department of Justice.

There is now more reason than ever for youngsters with these problems and their families to lead normal, happy lives.

Important Messages About Children's and Adolescents' Mental Health:

- Every child's mental health is important.
- Many children have mental health problems.
- These problems are real and painful and can be severe.
- Mental health problems can be recognized and treated.
- Caring families and communities working together can help.
- Information is available; call 1.800.789.2647.

For free information about children's and adolescents' mental health—including publications, references, and referrals to local and national resources and organizations—call 1.800.789.2647; TTY 301.443.9006.

5.13.96

BEST COPY AVAILABLE

A Few References on the Basics of Helping and Counseling

Basch, M. (1995). *Doing brief psychotherapy*. New York: Basic Books.

Brown, D.T. & Prout, H.T. (Eds.) (1989). *Counseling and psychotherapy with children and adolescents: Theory and practice for school and clinic settings* (2nd ed.). Brandon, VT: CPPC.

Gilliland, B.E., & James, R.K. (1993). *Crisis intervention strategies.* (2nd ed.). Pacific Grove, CA: Brooks/Cole.

Hames, C.C. & Joseph, D.H. (1986). *Basic concepts of helping: A holistic approach.* Norwalk, CT: Appleton-Century-Crofts.

Lauver, P. & Harvey, D.R. (1997). *The practical counselor: Elements of effective helping.* Pacific Grove, CA: Brooks/Cole.

Martin, D.G. & Moore, A.D. (1995). *First steps in the art of intervention: A guidebook for trainee in the helping professions.* Pacific Grove, CA: Brooks/Cole.

Meier, S.T. & Davis, S.R. (1997). *The elements of counseling* (3rd ed.) Pacific Grove, CA: Brooks/Cole.

Okun, B.F. (1997). *Effective helping: Interviewing and counseling techniques* (5th ed.). Pacific Grove, CA: Brooks/Cole.

Orton, G.L. (1997). *Strategies for counseling with children and their parents.* Pacific Grove, CA: Brooks/Cole.

Palamatier, L. *Crisis counseling: Grades K-9.* Bristol, PA: Taylor & Francis.

Test Questions – Unit II: Section B

(1) The immediate objective of psychological first-aid is to

___(a) eliminate the fear individuals experience during and in the immediate aftermath of a crisis
___(b) help individuals deal with troubling psychological reactions during and in the immediate aftermath of a crisis
___(c) tell students counseling will be made available to them
___(d) all of the above

(2) Three phases of crisis intervention are (a) managing the situation, (b) mobilizing support, and (c) following-up.

___True ___False

(3) The following list mixes together general activities related to providing psychosocial guidance and support with specific things that can be done to facilitate student communication in a psychosocial counseling situation.

Put a + before the items that describe general activities related to providing psychosocial guidance and support.

___(a) advising
___(b) providing advocacy and protection
___(c) responding with empathy, warmth, nurturance, and positive regard
___(d) providing support for transitions
___(e) listening with interest
___(f) creating a private space and a climate where the student can feel it is safe to talk
___(g) clarifying the role and value of keeping things confidential
___(h) encouraging the student to take the lead
___(i) providing mediation and conflict resolution
___(j) promoting and fostering opportunities for social and emotional development
___(k) being a liaison between school and home
___(l) being a liaison between school and other professionals serving a student

Section C: Consent, Due Process, and Confidentiality

"Clearly, confidentiality mandates are very important and they need to be upheld. They have been developed to protect basic rights to privacy which all service providers must closely guard and carefully respect. Also, It must be recognized that in addition to governmental legal requirements, most professional disciplines have legal obligations or strong ethical standards that prohibit release of information about a client, patient, or student without consent.

> Confidentiality requirements involving interagency collaboration certainly are not new. ...what is new is that in the current environment there exists a growing expectation that organizations routinely will work together to help children and families. Put into practice, this expectation has several implications in the area of information sharing: it means that an exchange of information is likely to be sought in substantially more cases, that more organizations are likely to be involved in the exchange, and that more detailed information is likely to be desired. In brief, questions that once were rarely asked about vulnerable children and families are now far more likely to be commonplace.

As interagency collaboration efforts gain momentum, service providers from education, mental health, child welfare, and health agencies increasingly find themselves in a very delicate *dilemma.*"

William Davis, 1994

Contents:

Consent and Due Process
Confidentiality

Objectives for Section C

After completing this section of Unit II, you should be able to:

- identify the three major aspects of the legal concept of consent
- identify at least two primary reasons for maintaining confidentiality in the delivery of mental health services
- identify two major exceptions to client confidentiality in a psychosocial counseling situation

A Few Focusing Questions

- *What does the term informed consent really mean?*
- *What due process rights do parents have?*
- *What are the primary reasons for ensuring confidentiality?*
- *What are the major exceptions to ensuring a student that what is said in counseling will be kept confidential?*

Before leaving the topic of mental health services and instruction, a few words are in order about some fundamental legal and ethical considerations.

Consent and Due Process

There was a time not so long ago when assessing students with problems and assigning them to special programs was done matter-of-factly. Most professionals believed they knew who needed help and what help was needed. It was a relatively simple matter to inform those involved that a problem existed and what was to be done. Growing awareness of rights and of the potentially harmful effects of treatment led to safeguards. Currently, consent is not taken for granted.

> Parent organizations and child advocates have insisted that parents be involved in any decision that might have a profound effect on the course of a child's life. This fact is reflected in the "procedural safeguards" enacted into federal law. These safeguards are rooted in the legal concept of due process as established in the Fourteenth Amendment to the federal constitution.

Due process protects people's rights; procedural safeguards are meant to help guarantee that everyone is treated fairly. They are meant to ensure that parents are involved in decisions regarding testing and placement of their child. That is, such interventions are not supposed to take place without parental consent.

Some of the safeguards spelled out in law are:

1. Parents must be notified whenever the school plans to conduct a special evaluation of their child.

2. Parents have the right to refuse consent for such an evaluation. (However, the school district has the right to a legal hearing to prove it is needed. Should parents want a special evaluation and the school refuses to provide it, parents can seek a legal hearing.)

3. Parents have the right to

   - review the procedures and instruments to be used in any evaluation
   - be informed of the results and review all records
   - obtain an independent educational evaluation to be considered in any decisions.

4. Parents must be notified whenever the school wants to change their child's educational placement, and they have the right to refuse consent for such a change. (Again, the school district can ask for a legal hearing to overrule the parents' decision. And, parents who are unable to convince the school to provide the special placement they want can also seek such a hearing.)

All notifications and explanations are to be given in the parents' primary language or other primary mode of communication.

What basic information should be communicated and understood? It is important to clarify the purpose of all intervention activity (why the person is there; what the person will be doing), describe risks and benefits, spell out alternatives, assure the individual that participation is not required, and elicit and answer all questions.

To make sure information is understood, it may need to be presented in a variety of ways. Repeated verbal or written communications, translations, media presentations, question-and-answer follow-ups to evaluate how information was understood, feedback obtained from other consumers -- all may be relevant at various times.

The emphasis on information, and the very term *informed consent*, may sometimes lead to greater emphasis on giving information than on ensuring true consent. Consent is a legal concept that has three major aspects: *capacity*, *information*, and *voluntariness*.

All three elements are of equal importance. These elements can be captured by three questions: Does the person have the ability to consent? adequate information to do so knowledgeably? the freedom to decline?

STOP. THINK. DISCUSS

Older students often want or need access to services without their parents knowing and with confidentiality protected.

When can students seek assistance without parent involvement?

Where the laws allows, licensed professionals can offer some sensitive services without parent consent. School-based health centers allow for open access once parents have signed an initial consent form that allows the student to use designated services.

In many instances, however, students are not in a position or motivated to follow-through with a referral -- even though their problems may be severe. Thus, more often than not, parent involvement is needed to facilitate follow-through. For example, students may need parents to pay fees and for transportation. If a student is not an emancipate minor, the referral resource will probably require parental consent.

When parent involvement is indicated, the referral intervention includes efforts to help students understand the benefits of such involvement and encourage them to discuss the matter with their parents. School staff can play a major role in facilitating and perhaps mediating a student-parent discussion for students who see the need but are fearful of approaching their parents without support.

What if a student is determined not to involve parents? Except when inaction would place the student or others in extreme danger, some school staff prefer to honor a student's desire to maintain confidentiality. In such instances, the only course of action open is to offer whatever referral follow-up support the school can provide. Some staff, however, believe it is essential for parents to take responsibility for student follow-through. Thus, parents are given referral information, asked to see that the student makes contact, and any needed follow-through support is directed at the parents.

Confidentiality

A typical dilemma: *John told me in confidence that he is planning a wild weekend with his friends. Given his history of substance abuse and what I know about the friends he mentioned, I'm worried that things will get out of control. Should I warn his parents?*

A Student asks: ***If I tell you something, will you tell my parents?***

How do you respond?

Confidentiality is an ethical concern. The fundamental intent is to protect a student's/family's right to privacy by ensuring that matters disclosed are not relayed to others without informed consent. By ensuring confidentiality, professionals also hope to encourage communication.

Neither privacy nor confidentiality, however, are absolute rights, especially in the case of minors. There are fundamental exceptions, some involving ethical considerations and some involving legalities.

There are times when professionals would prefer to maintain confidences but cannot do so legally or ethically. Examples include instances when individuals being seen indicates an intention to harm themselves or someone else and when they have been abused. As a result of legislation, litigation, and ethical deliberations, professional guidelines call on interveners to breach the confidence and tell appropriate public authorities when there is a clear danger to the person or to others. Undoubtedly, breaking confidentiality in any case can interfere with the trust between you and a student and make it difficult to help. Prevailing standards, however, stress that this concern is outweighed by your responsibility to prevent various threats.

In this vein, but perhaps going a step further, the ethical guidelines for school counselors call for reporting instances when information provided by clients indicates circumstances likely to have a negative effect on others; that is, without revealing the identity of the client, the counselor is expected to report such circumstances "to the appropriate responsible authority." However, it is left to individual counselors to decide which circumstances are "likely" and what constitutes a "negative effect" that is serious enough to require reporting. One result of all this is to make the processes of ensuring privacy and building trust almost paradoxical.

STOP. THINK. DISCUSS

What the primary reasons for ensuring the confidentiality of information about children and families.

Soler and Peters (1993) stress:

The fundamental right "to be let alone" is at the root of confidentiality protections. Confidentiality restrictions protect the privacy of individuals and insure that personal information is disclosed only when necessary. The reasons for respecting the privacy of children and families include the following:

a. Confidentiality restrictions protect embarrassing personal information from disclosure. This may include histories of emotional instability, marital conflicts, medical problems, physical or sexual abuse, alcoholism, drug use, limited education, or erratic employment.

b. Confidentiality provisions prevent improper dissemination of information about children and families that might increase the likelihood of discrimination or harm against them even if records show that the information is unproven or inaccurate. Such information includes HIV status, mental health history, use of illegal drugs or child abuse charges.

c. Protecting confidential information can be necessary to protect personal security. For instance, an abused woman in a domestic violence situation may be in great danger if law enforcers reveal her new location.

d. Confidentiality provisions also protect family security. For example, many immigrant families shy away from using public health clinics or other social services for that the Immigration and Naturalization Service (INS) will take action against them.

e. Restricting information disclosure may also protect job security. Information such as history of mental health treatment may bear no relation to job performance but could jeopardize the individual's position or ability to find employment.

f. Children and families want to avoid prejudice or differential treatment by people such as teachers, school administrators, and service providers.

g. Confidentiality provisions also may be necessary to encourage individuals to make use of services designed to help them. Adolescents may avoid seeking mental health services at a school-based clinic, for example, if they believe that information will get back to their teachers, parents or peers.

(From *Who should know what? Confidentiality and information sharing in service integration* published by the National Center for Service Integration).

States vary in the degree to which their laws specify limitations on privileged communication between counseling professionals and minor clients. Some protect only disclosures about problems related to alcohol and other drugs. Others give broad protection, specifying a few exceptions such as reporting child abuse and crime or potential criminal activity.

In order to adequately inform minors of exceptions to the promise of privacy, you can add a statement, such as

> Although most of what we talk about is private, there are three kinds of problems you might tell me about that we would have to talk about with other people. If I find out that someone has been seriously hurting or abusing you, I would have to tell the authorities about it. If you tell me you have made plan to seriously hurt yourself, I would have to let your parents know. If you tell me you have made a plan to seriously hurt someone else, I would have to warn that person. I would not be able to keep these problems just between you and me because the law says I can't. Do you understand that it's OK to talk about most things here but that these are three things we must talk about with other people?

Because youngsters may feel a bit overwhelmed about the exceptions to privacy and the serious problems described, they may simply nod their acquiescence or indicate that they are unsure about how to respond. To soften the impact, you may want to add statements, such as

> Fortunately, most of what we talk over is private. If you want to talk about any of the three problems that must be shared with others, we'll also talk about the best way for us to talk about the problem with others. I want to be sure I'm doing the best I can to help you.

There will be times when you find it in the best interest of a student for others to know something that he or she has disclosed. Most ethical guidelines on confidentiality recognize this. In doing so, guidelines stress that such sharing should occur "only with persons clearly concerned with the case." Given that teachers and parents are clearly connected and see themselves as also working in a student's best interests, some interveners feel it appropriate -- even essential -- to discuss information with them. In other words, there are times when keeping a specific confidence shared by a student works against the youngster's best interests. At such times, you may decide that the costs of not communicating the information to others outweighs the potential benefits of maintaining privacy. Obviously, the first step in such situations is to talk with the student and try to elicit consent for sharing. If you decide you must proceed without consent, you will want to inform the student of why you will be doing so and work to repair any damage to your relationship.

Note: For more on this topic, you may want to request the introductory packet on *Confidentiality and Informed Consent* from the Center for Mental Health at UCLA.

Privacy and Confidentiality

There are numerous reasons why it is important to maintain confidentiality in the delivery of health care services to adolescents. Possibly the most important is to encourage adolescents to seek necessary care, but additional reasons include supporting adolescents' growing sense of privacy and autonomy and protecting them from the humiliation and discrimination that could result from disclosure of confidential information.

The confidentiality obligation has numerous sources in law and policy. They include: the federal and state constitutions; federal statues and regulations (such as those which pertain to Medicaid, Title X family planning programs, federal drug and alcohol programs, Title V maternal and child health programs, or community and migrant health centers); state statutes and regulations (such as medical confidentiality statutes, medical records statutes. privilege statutes, professional licensing statutes, or funding statutes); court decisions; and professional ethical standards.

Because these varied provisions sometimes conflict, or are less than clear in their application to minors, it is important that practitioners have some general guidelines to follow -- or questions to ask -- in developing their understanding how to handle confidential information. Confidentiality protections are rarely, if ever, absolute, so it is important for practitioners to understand what *may* be disclosed (based on their discretion and professional judgement), what *must* be disclosed, and what *may not* be disclosed. In reaching this understanding, a few of the most relevant questions include: What information is confidential (since it is confidential information that is protected against disclosure)? What information is not confidential (since such information is not protected)? What exceptions are there in the confidentiality requirements? What information can be released with consent? What other mechanisms allow for discretionary disclosure? What mandates exist for reporting or disclosing confidential information?

In general, even confidential information may be disclosed as long as authorization is obtained from the patient or another appropriate person. Often, when minors have the legal right to consent to their own care, they also have the right to control disclosure of confidential information about that care. This is not always the case, however, since there are a number circumstances in which disclosure over the objection of the minor might be required: for example, if a specific legal provision requires disclosure to parents; a mandatory reporting obligation applies, as in the case of suspected physical or sexual abuse; or the minor poses a severe danger to himself or others.

When the minor does not have the legal right to consent to care, or to control disclosure, the release of confidential information must generally be authorized by the minor's parent or the person (or entity) with legal custody or guardianship. Even when this is necessary, however, it is still advisable -- from an ethical perspective -- for the practitioner to seek the agreement of the minor to disclose confidential information and certainly, at minimum, to advise the minor at the outset of treatment of any limits to confidentiality. Fortunately, in many circumstances, issues of confidentiality and disclosure can be resolved by discussion and information agreement between a physician, the adolescent patient, and the parents without reference to legal requirements.

Excerpted from "The Legal Framework for Minor Consent" by Abigail English written as the introduction to *State Minor Consent Statutes: A Summary* (April, 1995) prepared by the National Center for Youth Law (authored by M. Mathews, K. Extavour, C. Palamountain, & J. Yang).

Finally, it should be noted that the sharing of confidential information within and across agencies can be facilitated through developing a *Consent to Exchange Confidential Information*. The forms on the following pages illustrate those that are being developed around the country to overcome the barriers to the type of sharing that is essential in coordinating services.

Note that the form is designed to meet the varying demands of federal and state laws and education codes.

CHILDREN'S INTERAGENCY

CONSENT TO EXCHANGE CONFIDENTIAL INFORMATION

PLEASE TYPE/PRINT ALL INFORMATION

Child's Name _____ Birth Date _____

Mother's Maiden Name_____ Father's Name_____

Social Security No_____ Record No. _____

I authorize_____
to exchange information with

_____
Agency/Person/Organization

_____
Address

about information obtained during the course of my/my child's treatment/case/service plan for

_____

The exchange of records authorized here is required for the following purpose:

_____

Restriction: Release or transfer of the specified information to any person or agency not named herein prohibited unless indicated below:

Such exchange shall be limited to the following specific types of information: _____

_____

_____

This consent is subject to revocation by the undersigned at any time. It shall terminate, without express revocation on:

_____
Date, Event, or Condition

I understand I am entitled to receive a copy of this consent._____ copy(ies) requested and received.
I have read this consent carefully and have had all my questions answered.

Date_____ Witness _____

Signed_____ Signed _____
Parent, Guardian, Conservator Case Manager/County Representative

Agency _____

Confidential Client Information

SEE CALIFORNIA WELFARE AND INSTITUTIONS CODE SECTION 5328 AND SECTION 10850, CIVIL CODE 34, 58 AND 1798, 42 C.F.R. SECTION 2.34 AND 2.35, EDUCATION CODE 49075, HEALTH AND SAFETY CODE 1795

BEST COPY AVAILABLE

RELEASED RECORDS

The following records and/or information was released to:

_____

____ Summary of Record

____ Diagnosis / Assessment

____ Social History

____ Treatment Plan

____ Financial Information

____ Psychiatric Evaluation

____ Medical Assessment, Lab, Test, etc.

____ History of Drug / Alcohol Abuse

____ Other Evaluation / Assessment (specify)

_____

_____

_____

_____

____ Results of Psychological/ Vocational Testing

____ Other (specify)

_____

_____

_____

_____

_____

_____

_____

_____

_____

Released by:

SIGNATURE _____

TITLE _____ DATE _____

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Citation Examples:

Health and Safety Code 5
W&I Code 10850 and 5328
Ed. Code 49075
Civil Code 56 and 1796
42 CFR Part 2

Case Name:

Case Record No.:

Date of Birth:

BEST COPY AVAILABLE

Test Questions -- Unit II: Section C

(1) Which of the following are major aspects of the legal concept of consent?

___(a) a person must have the capacity to consent
___(b) a person must have appropriate and sufficient information before being asked to consent
___(c) a person's consent must be given voluntarily
___(d) a and b
___(e) a and c
___(f) b and c
___(d) all of the above

(2) It is important to maintain a client's confidentiality to protect embarrassing information from disclosure.

___True ___False

(3) It is important to maintain a client's confidentiality to minimize the likelihood of discrimination against the person.

___True ___False

(4) It is important to be able to offer confidentiality to encourage individuals to use services.

___True ___False

(5) Identify two major exceptions to client confidentiality in a psychosocial counseling situation.

_____ _____

Coda: Networks of Care

Mental health services and instruction that fosters positive social and emotional development represent major facets of what must done to address barriers to student learning. Increasingly, it is evident that many staff members at a school can play an important role in these arenas. In doing so, they can demonstrate their ability to offer a wider range of services and can help ensure that students are approached in a holistic way.

Moreover, by working with colleagues both within the school and throughout the surrounding community, school staff can help enhance systems for referral, triage, and management of care and expand the available network of care. At the same time, they can help schools move toward more comprehensive, integrated approaches that can prevent as well as respond to problems. In the process, all school staff can take their place as leaders for the type of systemic reforms that are essential in providing a safety net of care for generations to come.

ADDRESSING BARRIERS TO LEARNING: NEW DIRECTIONS FOR MENTAL HEALTH IN SCHOOLS

Follow-Up Reading

ABCs of Assessment

Managing and Preventing School Misbehavior and School Avoidance

ADDRESSING BARRIERS TO LEARNING: NEW DIRECTIONS FOR MENTAL HEALTH IN SCHOOLS

ABCs of Assessment

. . .a follow-up reading to provide an expanded perspective related to the unit on *Mental Health Services & Instruction: What a School Can Do*

In schools, assessment is most often associated with the various efforts devoted to assessing student achievement and the work of school psychologists. The fact is, of course, that school staff are involved everyday in some form of assessment activity.

The material on screening/assessment covered in the continuing education unit on *Mental Health Services and Instruction: What a School Can Do* provides a bridge between screening for physical problems and assessing psychosocial and mental health concerns.

This follow-up reading is designed as an enrichment activity that can help you put the many facets and functions of assessment at a school site into a broad perspective. Such a perspective is essential to every school's effort to minimize fragmented and piecemeal approaches and enhance coordinated and integrated to assessment.

ABCs OF ASSESSMENT

From:
Learning Problems and Learning Disabilities: Moving Forward (1993) by H.S. Adelman & L. Taylor

Schools committed to the success of all children must have an array of activities designed to address barriers to learning. No one is certain of the exact number of students who require assistance in dealing with such barriers. There is consensus, however, that significant barriers are encountered by a majority of students (see Exhibit).

Each day school staff are confronted with many students who are doing poorly in school as a result of health and psychosocial problems. Increasingly, education reform and restructuring are changing the whole fabric of schools and calling upon all personnel to expand their roles and functions.

As a result, school staff need to acquire new ways of thinking about how schools should assess these barriers in order to plan effective ways to address them.

Assessment Defined

Assessment is a broad-based concept. The term has been adopted to encompass narrower, medically related processes such as diagnosis, screening, and diagnostic testing.

In practice, the overall aim of assessment is to describe and make judgments as an aid to decision making. The judgments may represent a conclusion about the past (such as what caused a problem), a statement about the present (such as how severe a problem is), or a prediction about the future (such as how much the problem will improve as a result of intervention).

Formally defined, assessment is the process by which attributes of phenomena are *described* and *judged*. Descriptions take the form of data gathered by formal and informal measures, such as tests and observations of behavior or settings. Judgments take the form of interpretive conclusions about the meaning of data, such as whether a phenomenon is good or bad, above or below standard, pathological or not. Choices about what data to gather and what to exclude are guided by the types of judgments and decisions to be made (diagnostic classification, placement, remediation).

Controversy surrounds prevailing approaches to assessment. Although some of the controversy is about the deficiencies and limitations of specific procedures, broader concerns and criticism have been directed at the way assessment is used to shape research and practice and related policy decisions. Even when relatively objective assessment data are used, subsequent decisions often are extremely subjective. This is not surprising,

Exhibit

Barriers to Learning, Parenting and Teaching

(beyond medical/dental needs)

A. Deficiencies in basic living resources and opportunities for development

- dearth of food in the home
- inadequate clothing
- substandard housing (incl. being homeless)
- lack of transportation
- income at or below the poverty level (e.g., due to unemployment or welfare status)
- lack of after-school supervision for child
- immigrant-related concerns (e.g., limited English proficiency, legal status)

B. Observable problems

- school adjustment problems (incl. prevention of truancy, pregnancy, dropouts)
- relationship difficulties (incl. dysfunctional family situations, insensitivity to others)
- language difficulties
- abuse by others (physical and sexual)
- substance abuse
- emotional upset
- delinquency (incl. gang-related problems and community violence)
- psycho-social concerns stemming from sexual activity (e.g., prevention of and reactions to pregnancy or STD's)
- psychopathology

C. General stressors and underlying psychological problems associated with them

- external stressors (objective and perceived) and deficits in support systems
- competence deficits (low self-efficacy/self-esteem, skill deficits)
- threats to self-determination/autonomy/control
- feeling unrelated to others or perceiving threats to valued relationships
- personality disorders or psychopathology

D. Crises and emergencies

- personal/familial (incl. home violence)
- subgroup (e.g., death of a classmate or close colleague)
- school-wide (e.g., earthquake, floods, shooting on campus)

E. Difficult transitions

- associated with stages of schooling (e.g., entry. leaving)
- associated with stages of life (e.g., puberty, job and career concerns)
- associated with changes in life circumstances (e.g., moving, death in the family)

given that most decisions involve considerations that go well beyond the availability of valid data. More often than not, complex social-political-economic value questions are involved. Indeed, in some cases seemingly relevant data are ignored in order to arrive at a decision that the decision makers see as viable and beneficial.

> *Assessment does not have to be restricted to persons; environments and person-environment transactions can be assessed as well. With learning problems, however, assessment continues to be viewed in terms of screening and diagnosis and is shaped primarily by the presumption that problems stem from and belong to targeted individuals.*
>
> *Assessment does not have to be restricted to problems; strengths and interests can also be identified and may be important in correcting problems. Prevailing practices, however, continue to de-emphasize assessment of such positive attributes.*

What should be clear is that assessment is a complex matter. Despite the importance of assessment, prevailing assessment procedures potentially detrimental limitations and consequences:

- Assessment procedures do not have sufficient validity to warrant large-scale programs aimed at early identification;
- Assessment procedures are not capable of producing appropriate differential diagnoses and placements
- These procedures often lead to the misprescription of remediation, the de-emphasis of the importance of a person's strengths and interests, and they narrow the focus of school curricula
- These procedures can inappropriately shape evaluation and eventually redefine and limit objectives.

Furthermore, overemphasis on assessment practices that focus on persons hinders development of procedures for assessing the role of the environment. As a result of the bias toward localizing problems within persons, interventions tend to be person-centered. Almost by presumption, environmental variables are exonerated as causal factors and as the focal point of intervention.

In spite of the deficiencies of prevailing practices, each day professionals are called upon to assess and make decisions about individuals. Unfortunately, for now they must do so using a relatively weak knowledge base.

The need for improved practices is evident. Fortunately, recent research has pointed to promising approaches that go beyond conventional procedures. There may be major concerns about the state of the art, but there can be no doubt that persons with problems can and must be helped.

Functions

As seen in Figure on the next page, the major purposes of assessment can be grouped into four categories of function. These four functions represent the types of decisions for which such assessment may be useful.

1. ***Identification***. Data are used to help find and label phenomena of interest. The focus may be on a person, the environment, or both, and may or may not be on problems.

2. ***Selection***. Data are used to help make decisions about general changes in status. These usually are discussed as placement decisions, but they also encompass decisions about changes in environments. Specifically, these are decisions about the general nature and form of needed intervention (for example, educational, psychological, or medically oriented treatments; placement in a special setting; changes in the organization of a classroom or school).

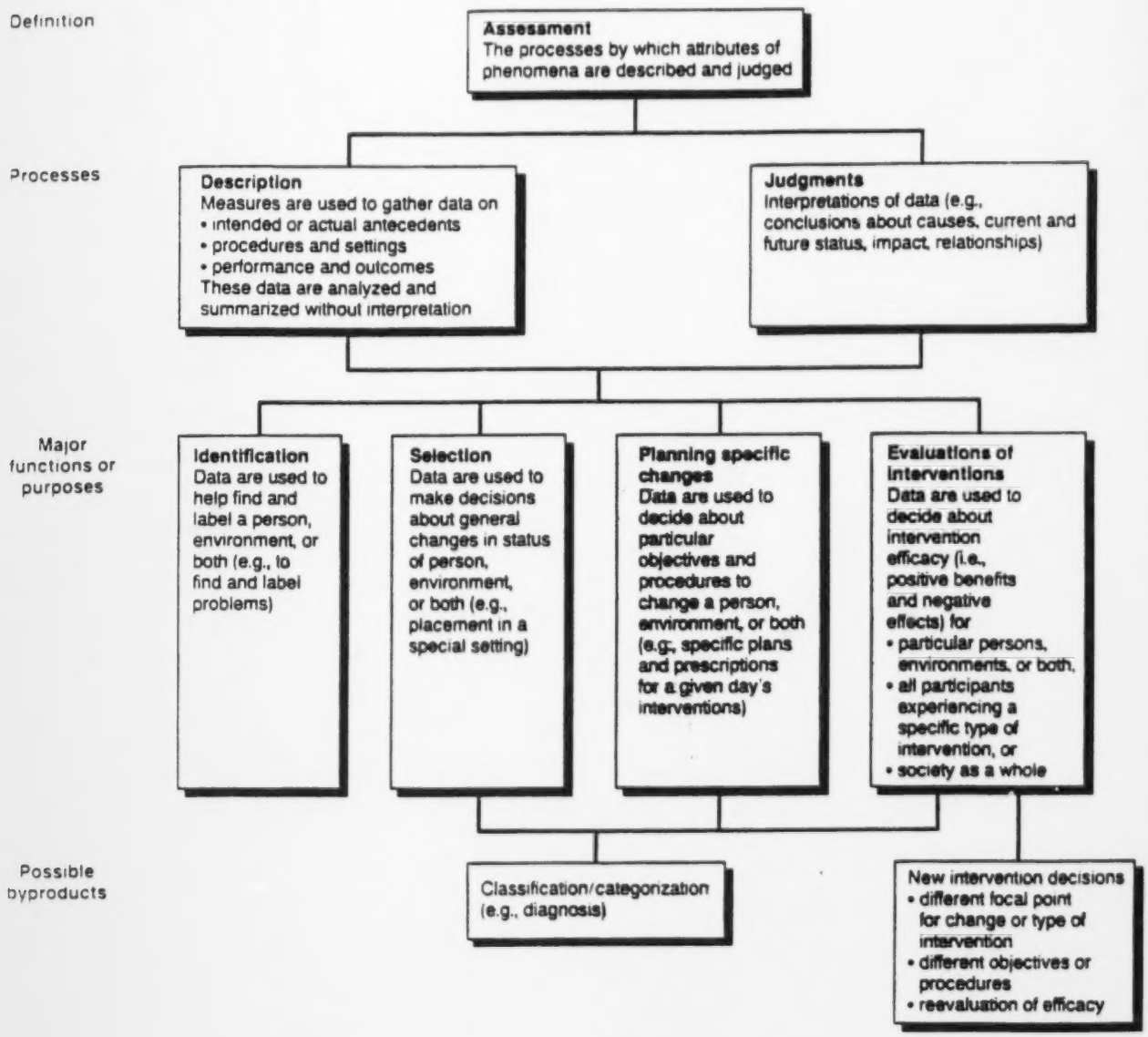
3. ***Planning for specific change***. Data are used to decide about immediate and short-term objectives and procedures for accomplishing long-term goals. Examples are specific plans or prescriptions for any given day's intervention.

4. ***Evaluation of Intervention***. Data are used to decide intervention effectiveness based on positive and negative outcomes. Decisions may be made with reference to the impact on (a) particular persons or environments or both, (b) all experiencing a specific intervention, or (c) society as a whole.

An example may help clarify the preceding points. Achievement tests are often used to assess reading performance in a given school. The number of right and wrong answers provides a description of performance on a given set of items at a given time. Based on these descriptive data, a variety of judgments are likely to be made. They will be based on available norms and prevailing standards.

Different judgments will be made about individuals with identical scores who differ in age. Different judgments may be made about groups living in economically advantaged and disadvantaged communities.

Figure *Assessment Processes and Purposes*


Definition
Assessment
The processes by which attributes of phenomena are described and judged
Processes
Description
Measures are used to gather data on
• intended or actual antecedents
• procedures and settings
• performance and outcomes
These data are analyzed and summarized without interpretation
Judgments
Interpretations of data (e.g., conclusions about causes, current and future status, impact, relationships)
Major functions or purposes
Identification
Data are used to help find and label a person, environment, or both (e.g., to find and label problems)
Selection
Data are used to make decisions about general changes in status of person, environment, or both (e.g., placement in a special setting)
Planning specific changes
Data are used to decide about particular objectives and procedures to change a person, environment, or both (e.g., specific plans and prescriptions for a given day's interventions)
Evaluations of interventions
Data are used to decide about intervention efficacy (i.e., positive benefits and negative effects) for
• particular persons, environments, or both,
• all participants experiencing a specific type of intervention, or
• society as a whole
Possible byproducts
Classification/categorization (e.g., diagnosis)
New intervention decisions
• different focal point for change or type of intervention
• different objectives or procedures
• reevaluation of efficacy

BEST COPY AVAILABLE

Decisions will be made about whether to assign diagnostic labels to individuals and programs judged to be performing poorly. That is, an individual might be labeled as having a learning disability; a school could be labeled as failing to do its job.

Decisions will be made as to whether some individuals and schools should be helped, and if so, specific plans may be formulated. At a later date, achievement test data again will be used to evaluate performance.

Other Factors Shaping Assessment

In addition to having four major purposes, activity related to assessment occurs in phases, and differs in terms of focus and types of procedures used (see Table). There are a variety of options in deciding what and how to assess.

For example, stimulus-and-response conditions may differ in terms of the number of variables assessed, their complexity, and whether they are simulated or natural. Variations also occur with respect to (a) how ambiguous and subjective the stimuli are, (b) how well standardized the administration procedures are, (c) how obtrusive the procedures are, and (d) how much they cause unintended reactions. There are also important considerations about similarities and differences between the assessor and the assessed (for example, in terms of race, cultural background, socioeconomic status, and gender).

Although such variations in practice influence both the form of assessment activity and the findings, there is little agreement and considerable concern about their impact.

New Directions

New opportunities are emerging as schools attempt to reduce fragmentation through various reform strategies. Assessments focused on individual students and on evaluating instructional effectiveness are being linked in thoughtful new ways. On the following pages are some exerpts from a digest published by the ERIC clearinghouse on Counseling and Student Services that illustrates these changes. The document is entitled *Emerging Student Assessment Systems for School Reform* (ERIC Digest, Number ED389959 95) and is authored by Edward Roeber.*

*Created by eric, the educational resources information center. For more information about eric, contact ACCESS ERIC 1-800-LET-ERIC. Edward D. Roeber is Director of Student Assessment Programs, Council of Chief State School Officers in Washington, D.C. ERIC Digests are in the public domain and may be freely reproduced and disseminated. This publication was funded by the U.S. Department of Education, Office of Educational Research and Improvement, Contract No. RR93002004. Opinions expressed in this report do not necessarily reflect the positions of the U.S. Department of Education, OERI, or ERIC/CASS.

Table *Nature and Scope of Assessment Activity*

I. *Functions and purposes of assessment*
- A. **Identification**
  1. Screening and referral
  2. Diagnostic labeling
  3. Nonpathological attributes
- B. **Selection/placement**
  1. Clarification of options
  2. Client decisions about general changes in status
  3. Professional and agency decisions to accept or reject applicants
- C. **Specific planning for change**
  1. Detailed objectives
  2. Detailed procedures
- D. **Evaluation of interventions**
  1. Individual efficacy
  2. Efficacy for all participants
  3. Impact on society

II. *Major phases related to assessment*
- A. **Preparatory decisions about what is to be assessed** (implicit or explicit rationale for assessment activity)
- B. **Description** ("measurements" of specified variables and serendipitous data gathering, followed by analyses and descriptive summaries)
- C. **Judgments** (interpretations)
- D. **Communication and decision making with reference to assessment purposes**

III. *Focus of assessment*
- A. **Focal point**
  1. Person(s)—individuals or groups of individuals
  2. Environment(s)
  3. Person–environment transactions
- B. **Nature of phenomena**
  1. Problematic–nonproblematic conditions
  2. Observable–inferred
  3. Proximal–distal
  4. Historic–current–future expectations
- C. **Levels**
  1. Molecular–molar analyses of persons
  2. Primary, secondary, tertiary contextual analysis
  3. Transaction of person–environment
- D. **Areas or domains**
  1. Biological and psychological processes
  2. Motor and verbal functioning
  3. Physical environment
  4. Social environment
  5. Transaction of person–environment

IV. *Types of procedures and instruments* (standardized, semi-standardized, or unstandardized)
- A. **Interviews and written personal reports** (responses to oral or written questions, inventories of items, etc.)
- B. **Observations**
- C. **Verbal and performance measures** (objective instruments such as achievement tests; projective instruments such as thematic pictures; instruments developed by teachers, psychologists, and MDs that have not been formally and technically standardized)
- D. **Biological tests** (electrorecording devices, chemical analyses)
- E. **Available records and data** (analyses of current or cumulated records related to person, environment, transactions; analyses of natural performances and products, such as portfolio assessment)

BEST COPY AVAILABLE

INTRODUCTION

Currently, much discussion is taking place about the quality of American schools, the skills needed by students, and the ways we should be assessing these achievements. Student assessment is viewed nationally as the pivotal piece around which school reform and improvement in the nation's schools turn. For example, student assessment is the key piece of Goals 2000, as well as other federal legislation such as the Elementary and Secondary Education Act (ESEA).

The result is that substantially more assessment is likely to occur in our nation's schools, and to take place in areas traditionally not assessed (such as the arts), using assessment strategies (such as performance assessments and portfolios) not typically used. States and local districts are reconsidering the models for systems of assessment and how assessment at the state and local levels can be coordinated to achieve the reforms desired in education...

HOW DOES REFORM OF ASSESSMENT FIT SCHOOL REFORM?

Student assessment is at the top of the list of things to tinker with by policy makers at the national and state levels, since it is viewed as a means to set more appropriate targets for students, focus staff development efforts for the nation's teachers, encourage curriculum reform and improve instruction and instructional materials in a variety of subject matters and disciplines (Darling-Hammond & Wise, 1985). Assessment is important because it is widely believed that what gets assessed is what gets taught, and that the format of assessment influences the format of learning and teaching. (O'Day & Smith, 1993). The hope of policy makers is that changes in assessment will not only bring about the needed changes in students, but also in ways schools are organized (Linn, 1987, Madaus, 1985). Interest in performance assessment has also been justified on the basis that using such measures will promote educational equity (National Center on Education and the Economy, 1989). Student assessment carries a heavy load these days!...

Assessment reform should occur along with professional development, instructional development, and other strategies designed to assure that all of the changes are mutually supported. Coordination of assessment reform at the national and state levels with assessments at the local level is also important, so that each will present a coherent view of student performance, not simply be "stuck" together.

TYPES OF ASSESSMENTS

New content standards may require different assessment methods. Among the assessment techniques now being considered are short-answer, open-ended; extended-response, open-ended; individual interviews; performance events; performance tasks in which students have extended time; projects; portfolios; observations; and anecdotal records, in addition to multiple-choice exercises. A broader repertoire of techniques is increasingly being used.

SCHOOL IMPROVEMENT STRATEGIES

The information about student achievement needed at various levels of the educational system is different. Parents have different needs than teachers, who in turn, have different needs than school principals. District administrators need broader, system-wide information, while at the state level, there is concern about equity across districts and identification of state priorities. Nationally, policy makers are concerned about differences between states and how competitive American students are with their peers in other countries.

Improving student achievement can take place at each of these levels. Teachers work with an individual student in a classroom, or revamp classroom-wide instruction based on an assessment. At the school level, educators use school information to set long-and-short-range objectives and decide how to accomplish these. At the district level, educators target particular areas of the curriculum for attention. At the state level, incentives for improving instructional programs may be most important. School reform occurs at all levels of the educational system.

(cont.)

BEST COPY AVAILABLE

USEFUL ASSESSMENT DESIGNS

Typically, student achievement is measured with available student test data, often using information from district or state testing programs. Information collected less formally in classrooms is not typically included in school improvement plans, even though such information could provide valuable insights into student learning.

The nature of information needs should form the basis for an assessment design. In a top-down model, policy makers develop an assessment design that meets their needs, hoping the data may be useful by persons at lower levels. An alternative is to build the assessment system needed at the local level, aggregating the information upwards to the district, state and national levels.

Another model, based on the assumption that multiple approaches will allow different users' needs to be met, is to develop a comprehensive assessment system using different assessment formats to meet different users' needs. Various assessment strategies can be implemented together at the different levels to provide for the different information needs in a coordinated, coherent manner (Darling-Hammond, 1994).

For example, local districts can adopt a portfolio system for improving instruction, while the state carries out matrix-sampling across important standards. The information collected by the state can become part of the student's portfolio, thereby strengthening the portfolio's quality. The state could also provide opportunities for teachers to learn to score the open-ended written and performance assessments, thereby enhancing teachers' capabilities of observing and rating student performances in their classrooms.

In this case, the elements of the system at the different levels build on and support the elements at other levels. It is also anticipated that information collected at the different levels can be reported in a more understandable manner, since the same standards apply in different ways. This assessment model enhances the reforms of schools so many desire.

SUMMARY

This is indeed a time when American schools are being challenged to provide opportunities for students to achieve at much higher levels. Assessment is viewed as one of the essential elements in assisting schools to address the standards now deemed to be important in a manner that will help all students to achieve them. The major challenge for assessment is to implement these additional assessments in a coordinated manner so that the amount of assessment is supportive of the changes needed, not overly burdensome to teachers or students. Models for coordination assessment at the state, district and classroom levels appear most promising.

REFERENCES

Darling-Hammond, L. and A. Wise (1985). Beyond standardization: state standards and schoolimprovement. Elementary School Journal, 85, 315-36.

Darling-Hammond, L. (Spring, 1994). Performance assessment and educational equity. Harvard Educational Review, 64 (1): 5-29.

Linn, R. (1987). Accountability: The comparison of educational systems and the quality of test results. Educational Policy, 1(2): 181-198.

Madaus, G. (1985). Public policy and the testing profession-you've never had it so good? Educational Measurement: Issues and Practices, 4 (1): 5-11.

National Center on Education and the Economy (1989). To secure our future: The federal role in education. Rochester, NY: Author.

O'Day, J.A. and M. Smith (1993). Systemic school reform and educational opportunity. In S, Fuhrman (Ed.), Designing coherent educational policy: Improving the system. San Francisco: Jossey-Bass, pages 250-311.

Roeber, E. (1992). 1. Developing the comprehensive assessment system: A. top down, B. bottom up, C. both, D. none of the above. Paper presented at the 1992 Education Commission of the States Conference on Large-Scale Assessment.

Controversy Over Assessment: The Changing Sociopolitical Climate

Throughout the 1970's and 1980's, judicial decisions were an important sociopolitical factor influencing legislation, policy making, and practice. In the courts, parents and advocacy groups pushed for the rights of those with disabilities and equality of education and fought discrimination.

Hobson v. Hansen (1969): This was the first major case raising questions about placement in special education. The court ruled that using test scores to group students into "tracks" was unconstitutional because it discriminated against blacks and the poor.

Diana v. State Board of Education (1970): Here was a case in which the use of tests to place students was again challenged. Diana, a Spanish-speaking student in Monterey County, California, had been placed in a class for mildly mentally retarded students because she had scored low on an IQ test given to her in English. The court ruled that Spanish-speaking children should be retested in their native language to avoid errors in placement.

Larry P. V Riles (1972): Larry P. Was a black student in California, and his complaint led to an expansion of the ruling in the Diana case. The court ruled that schools are responsible for providing tests that do not discriminate on the basis of race. In the class-action case of PASE v. Hannon (1980), however, the fudge stated he could find little evidence of bias in the test items. The Larry P. Case also set a precedent for the use of data indicating disproportionate placement of minority groups as prima facie evidence of discrimination. However, subsequent cases have undermined this precedent (Marshall et a. v. Georgia [1984] and S-I v. Turlington [1986]).

In many ways, it is unfortunate that litigation is necessary. But it is. It seems that many questions about the appropriate treatment of those who do not "fit in" are so unsettled and unsettling as to require adjudication.

Some basic References on Assessment in Schools

Learning Problems and Learning Disabilities: Moving Forward.
H.S. Adelman & L. Taylor. Brooks/Cole Publishing Co.; Pacific Grove, CA.1993.

Assessment.
J. Salvia & J.E. Ysseldyke. Houghton Mifflin Co.; Boston, MA: 1991.

Behavioral assessment.
E.S. Shipiro. In: *Handbook of Behavior Therapy in Education*. J.C. Witt, S.N. Elliot, & F.M.Gresham (Ed.s). Plenum Press: New York, NY: 1988. p. 67-98.

Measuring Up: Standards, Assessment, and School Reform.
R. Rothman. Jossey-Bass, Inc.; San Fransisco, CA: 1995.

Planning and Conducting Needs Assessment: A Practical Guide.
B.R. Witkins & J.W. Altschuld. Sage Publishers, Inc.; Thousand Oaks, CA: 1995.

ADHD in the Schools: Assessment and Intervention Strategies.
G.J. DuPaul & G.D. Stoner. Guilford Press; New York, NY: 1994.

Development of a questionnaire for assessing the school environment.
B. Melville, D. Brown, W. Segree, T. Paul, and others (1994-95). *International Quarterly of Community Health Education, 15,* 15-20.

Best Practices in Assessment for School and Clinical Settings.
H.B. Vance (Ed.). Clinical Psychology Publishing Co, Inc.; Brandon, VT: 1993.

Handbook on the Assessment of Learning Disabilities: Theory, Research, and Practice.
H.L. Swanson. Pro-Ed; Austin, TX: 1991

Brief Research Syntheses Available from the ERIC Clearinghouses.

The following are a few more of the many ERIC Digests (research syntheses) related to Assessment. They are available in libraries, over the Internet, or directly from the Educational Resources Information Center (ERIC) by phone, 1-800-LET-ERIC.

- 1995 -- ERIC Digest, number ED388 888 30. New Assessment Methods for School Counselors
- 1995 -- ERIC Digest, number EDO CG 95 3. Mental Health Counseling Assessment: Broadening One's Understanding of the Client and the Client's Presenting Concerns.
- 1995 -- ERIC Digest, number EDO CG 95 11. Emerging Student Assessment Systems for School Reform.

ADDRESSING BARRIERS TO LEARNING: NEW DIRECTIONS FOR MENTAL HEALTH IN SCHOOLS

Managing and Preventing School Misbehavior and School Avoidance

. . . a follow-up reading to provide an expanded perspective related to the unit on *Mental Health Services & Instruction: What a School Can Do*

Misbehavior at school and school avoidance are among the greatest sources of grief to teachers, administrators, and pupil personnel staff. Efforts to deal with such problems take up a disproportionate amount of time and energy. Worse yet, in some schools, the battle against such problems is being lost.

This follow-up reading is designed as an enrichment activity that can help you understand the motivational underpinnings of school misbehavior and avoidance and a broad perspective on strategies for dealing with such problems.

Managing and Preventing School Misbehavior and School Avoidance*

Interventions to deal with school misbehavior and avoidance can be viewed in terms of phases, namely, efforts to prevent and anticipate such problems, actions to be taken when an act is occurring, and steps to be taken afterwards. Part of the reason that prevailing practices have been so limited in effectiveness is that they have not been built on an understanding of the motivational bases for such problems.

An understanding of intrinsic motivation, in general, and reactive and proactive deviance, in particular, has major implications for each of these intervention phases. For example, with respect to prevention, regardless of theoretical orientation, most professionals recognize that social and school program improvements could reduce learning and behavior problems significantly. There is increasing acceptance that a primary preventive step involves normative changes in classroom programs. From the perspective of intrinsic motivation theory, such changes include designing classroom instruction to better match the broad range of differences in students' intrinsic motivation as well as their difference in capability. Indeed, such changes have been discussed as an essential prerequisite to individual intervention.

However, even if primary and secondary preventive steps are taken, there remains the necessity of intervening with individuals who continue to be troublesome. Discussions of practices for dealing with such students often are organized around the topics of discipline, classroom management, and student behavioral self-management. An appreciation of the role intrinsic motivation plays in deviant and devious behavior suggests approaches to such behavior that go beyond current disciplinary and management practices. Before discussing these matters, however, it is important to acknowledge the necessity of dealing with the *impact* of misbehavior and to highlight practical and research implications related to minimizing negative motivational and behavioral repercussions.

SCHOOL MISBEHAVIOR: DISCIPLINE, LOGICAL CONSEQUENCES, AND RECIPIENT PERCEPTIONS

The first concern of school personnel almost always is with the impact of misbehavior, and rightly so. Such behavior disrupts; it may be hurtful; it may disinhibit others. Thus, when a youngster misbehaves, a natural reaction is to want that youngster to experience, and other students to see, the consequences of misbehaving in hopes that consequences will deter subsequent misbehavior. That is, because the impact of misbehavior usually is the first concern, the primary focus of intervention usually is on *discipline*.

---

*This material is excerpted from the following works:
>*Learning Problems and Learning Disabilities: Moving Forward* (1993) by H.S. Adelman & L. Taylor
>School avoidance behavior: Motivational bases and implications for intervention (1990) by L. Taylor & H.S. Adelman published in *Child Psychiatry and Human Development*.

Given the primary role assigned to disciplinary practices in responding to school misbehavior, it is essential that their impact on intrinsic motivation be considered and investigated. Thus, some motivational concerns are highlighted here as a stimulus for practice and research.

Discipline

Knoff (1987) presents three definitions of discipline as applied in schools:

> (a) ... a punitive intervention; (b) ... a means of suppressing or eliminating inappropriate behavior, of teaching or reinforcing appropriate behavior, and of redirecting potentially inappropriate behavior toward acceptable ends; and (c) ... a process of self-control whereby the (potentially) misbehaving student applies techniques that interrupt inappropriate behavior, and that replace it with acceptable behavior (p. 119).

In contrast to the first definition which specifies discipline as punishment, Knoff sees the other two as nonpunitive or as he calls them "positive, best-practices approaches." He appears to make this distinction because of the general recognition that punishment is an undesirable form of discipline to be used only in an emergency.

Given current circumstances, school personnel often see punishment as the only recourse in dealing with a student's misbehavior. That is, they use the most potent negative consequences available to them in a desperate effort to control an individual and make it clear to others that acting in such a fashion will not be tolerated. Essentially, such punishment takes the form of a decision to do something to the student that he or she does not want done. In addition, a demand for future compliance usually is made, along with threats of harsher punishment if compliance is not forthcoming. And the discipline may be administered in a way that suggests the student is seen officially as an undesirable person.

As with many emergency procedures, benefits produced by using punishment may be offset by a variety of negative consequences (e.g., increases in negative attitudes toward school and school personnel which often lead to other forms of misbehavior). Thus, as soon as the emergency is resolved and in nonemergency situations, the emphasis often shifts from punishment to implementing logical consequences.

Logical Consequences and Recipient Perceptions

Guidelines for managing misbehavior generally emphasize the desirability of having discipline seen as reasonable, fair, and nondenigrating. Intrinsic motivation theory specifically stresses that "positive, best-practice approaches" are disciplinary acts recipients experience as legitimate reactions that neither denigrate one's sense of worth nor reduce one's sense of autonomy (e.g., Deci & Ryan, 1985). To these ends, discussions of classroom management practices usually emphasize establishing and administering logical consequences. This idea is evident in situations where there are naturally-occurring consequences (e.g., if you touch a hot stove, you get burned). In classrooms, there may be little ambiguity about the rules; unfortunately, the same often cannot be said about "logical" penalties. Even when the consequence for a

particular rule infraction has been specified ahead of time, its logic may be more in the mind of the teacher than in the eye of the students. Indeed, the distinctions made by Knoff reflect an observer's perspective of discipline. In the recipient's view, any act of discipline may be experienced as punitive (e.g., unreasonable, unfair, denigrating, disempowering).

Basically, consequences involve depriving students of something they want and/or making them experience something they don't want. Consequences usually take the form of (a) removal/ deprivation (e.g., loss of privileges, removal from an activity), (b) reprimands (e.g., public censure), (c) reparations (e.g., to compensate for any losses arising from the misbehavior), and (d) recantations (e.g., apologies, plans for avoiding future problems). For instance, teachers commonly deal with acting out behavior by removing a student from an activity. To the teacher, this step (often described as "time out") may be seen as a logical way to stop the student from disrupting others by isolating him or her, or the logic may be that the student needs a cooling off period. It may be reasoned that (a) by misbehaving the student has shown s/he does not deserve the privilege of participating (assuming the student likes the activity) and (b) the loss will lead to improved behavior in order to avoid future deprivation.

Most teachers have little difficulty explaining their reasons for using a particular consequence. However, if the intent really is to have students perceive consequences as logical and nondebilitating, it seems logical to determine whether the recipient sees a disciplinary act as a legitimate response to misbehavior. Moreover, it is well to recognize the difficulty of administering consequences in a way that minimizes the negative impact on the recipient's perceptions of self. That is, although the intent is to stress that it is the misbehavior and its impact that are bad, the student can too easily experience the process as a characterization of her or him as a bad person. Examples of an established, accepted set of consequences that gives major consideration to the recipient's perceptions occur in such organized sports as youth basketball and soccer. In these arenas, the referee is able to use the rules and related criteria to identify inappropriate acts and apply penalties; moreover, s/he is expected to do so with positive concern for maintaining the youngster's dignity as well as engendering respect for others.

For discipline to be seen as a logical consequence, it may be necessary to take steps to convey (a) that disciplinary responses are not personally motivated acts of power (e.g., an authoritarian action) and, at the same time, (b) that the social order has established rational reactions to a student's behavior which negatively affects others. Also, if the intent of the discipline is a long-term reduction in future misbehavior, it may be necessary to take steps to help students learn right from wrong, to respect others rights, and to accept responsibility. Towards these ends, motivational theorists suggest it may be useful to (a) establish a publicly accepted set of consequences to increase the likelihood that students experience them as socially just (e.g., reasonable, firm but fair) and (b) administer such consequences in ways that allow students to maintain a sense of integrity, dignity, and autonomy (e.g., Brehm & Brehm, 1981; Deci & Ryan, 1985). These ends are probably best achieved under conditions wherein students are *empowered* (e.g., are involved in deciding how to rectify the situation and avoid future misbehavior and are given opportunities for subsequent positive involvement and reputation building at school).

From a motivational perspective, then, it is essential to (a) gain a better understanding of recipient perceptions of discipline and (b) develop disciplinary practices that minimize negative repercussions. These are both areas where there is a dearth of direct research.

ADDRESSING UNDERLYING MOTIVATION

Beyond discipline, there is a need for research on interventions designed to address the roots of misbehavior, especially the underlying motivational bases for such behavior. Consider students who spend most of the day trying to avoid all or part of the instructional program. An intrinsic motivational interpretation of the avoidance behavior of many of these youngsters is that it reflects their perception that school is not a place where they experience a sense of competence, autonomy, and or relatedness to others. Over time, these perceptions develop into strong motivational dispositions and related patterns of misbehavior.

Relevant interventions for such problems begin with major changes in social and school programs. The aims of such changes with respect to motivational problems are to (a) prevent and overcome negative attitudes to school and learning, (b) enhance motivational readiness to learn and overcome problems, (c) maintain intrinsic motivation throughout learning and problem solving processes, and (d) nurture the type of continuing motivation that results in students engaging in activities away from school which can facilitate maintenance, generalization, and expansion of learning and problem solving. Failure to attend to these motivational concerns in a comprehensive, normative manner results in approaching passive and often hostile students with practices that can instigate and exacerbate many learning and behavior problems. After accomplishing broad programmatic changes to the degree feasible, intervention with a misbehaving student involves remedial steps directed at specific factors associated with unintentional, proactive and/or reactive deviance. Because the concern here is with intentional behavior problems, the focus in the following sections is primarily on reactive and proactive misbehavior. First, a few implications for counseling and consulting are highlighted and then implications for general changes in school programs are discussed.

Counseling and Consulting

Understanding the motivational ideas discussed above can profoundly influence research and practice focused on counseling individuals who misbehave and consulting with their teachers and parents. For instance, with intrinsic motivation in mind, the following assessment questions arise:

- Is the misbehavior unintentional or intentional?
- If it is intentional, is it reactive or proactive?
- If the misbehavior is reactive, is it a reaction to threats to self-determination, competence, or relatedness?
- If it is proactive, are there other interests that might successfully compete with satisfaction derived from deviant behavior?

Answers to these questions may be based on perspectives of cause related by teachers, parents, and the identified student. (Toward ruling out a skill deficit, data also are needed on the youngster's basic abilities.) However, because of attributional biases, one can expect these interested parties to offer different causal views. Rather than viewing these differences as confounding assessment, such data can help clarify the student's underlying motivation and how others interpret that motivation. Both matters can be seen as central to planning corrective strategies aimed at affecting the student's intrinsic motivation. That is, differing perceptions can compound a problem by resulting in different analyses of what's wrong and what should be done. Awareness of differences in perceived cause enables interveners to explore how these differences are affecting the actions of each interested party and to clarify which perceptions may be counterproductive in resolving the problem.

With respect to resolving the problem, intrinsic motivational theory suggests that individual corrective interventions for those misbehaving reactively requires steps designed to reduce reactance and enhance positive motivation for participating in an intervention. For youngsters highly motivated to pursue deviance (e.g., those who proactively engage in criminal acts), even more is needed. Intervention might focus on helping these youngsters identify and follow through on a range of valued, socially appropriate alternatives to deviant activity. From the theoretical perspective presented above, such alternatives must be capable of producing greater feelings of self-determination, competence, and relatedness than usually result from the youngster's deviant actions.

To these ends, motivational analyses of the problem can point to corrective steps for implementation by teachers, clinicians, parents, or students themselves. If misbehavior is unintentional, the focus of intervention at school, in the clinic, and at home probably only needs to be directed at reducing stress and building skills. However, if the behavior is intentional, all interested parties probably should be encouraged to

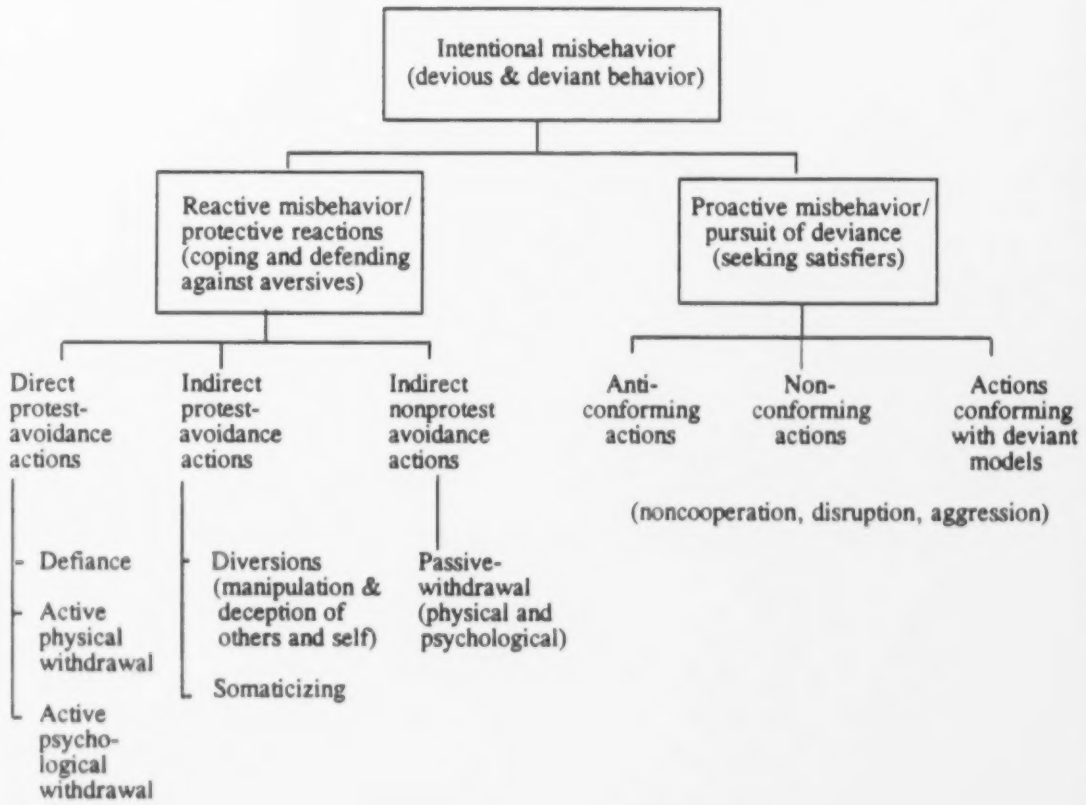
- eliminate situations leading to reactivity and establish alterative ways for the student to cope with what cannot be changed
- establish activity options designed to redirect proactive misbehavior toward prosocial interests and behavior.

For example, consultants might help teachers and parents understand motivational bases for a youngster's misbehavior and facilitate environment and program changes that account for the youngster's need to feel self-determining, competent, and related. Similarly, in direct counseling with students whose misbehavior is intentionally reactive, short-term work might stress increasing a student's awareness and how s/he can work with significant others to produce circumstances that better match his or her psychological needs. Comparable counseling might be provided to those exhibiting proactive deviance; however, evidence from delinquent populations suggests short-term counseling in such cases is rather ineffective. Indeed, for both groups, it must be acknowledged that little is known about how effective even long-term psychotherapy or behavior change strategies might be. Nevertheless, long-term intervention generally is described as providing the time frame necessary for dealing with students' affect, increasing their understanding of why they behave as they do, and exploring the possibility of change.

Reactively and Proactively Motivated Misbehavior

Youngsters frequently display a range of behaviors at school that are seen as inappropriate and troublesome. Such behavior can reflect proactive (approach) or reactive (avoidance) motivation. Noncooperative, disruptive, and aggressive behavior patterns that are proactive tend to be rewarding and satisfying to an individual because the behavior itself is exciting or because the behavior leads to desired outcomes (e.g., peer recognition, feelings of competence or autonomy). Intentional negative behavior stemming from such approach motivation can be viewed as *pursuit of deviance*.

Of course, misbehavior in the classroom often also is reactive, stemming from avoidance motivation. This behavior can be viewed as *protective reactions*. That is, students with learning problems can be seen as motivated to avoid and to protest against being forced into situations in which they cannot cope effectively. For such students, many teaching and therapy situations are perceived in this way. Under such circumstances, individuals can be expected to react by trying to protect themselves from the unpleasant thoughts and feelings that the situations stimulate (e.g., feelings of incompetence, loss of autonomy, negative relationships). In effect, the misbehavior reflects efforts to cope and defend against aversive experiences. The actions may be direct or indirect and include defiance, physical and psychological withdrawal, and diversionary tactics (as represented graphically below).



From a motivational perspective, an appropriate test of the efficacy of long-term psychotherapeutic and behavior change interventions for intentional misbehavior requires more than specifying what one wants youngsters to understand and do. Achievement of such objectives requires interventions that systematically address intrinsic motivation as key process or "enabling" objectives. To be specific, intervention must deal with the initial attitudes these youngsters are likely to bring to the counseling situation. They are unlikely to approach the process positively or even neutrally; that is, there are negative attitudes to overcome. Assuming negative attitudes are overcome, the intervener must be able to (a) enhance the youngster's motivational readiness to develop a working relationship and (b) maintain the youngster's positive intrinsic motivation for as long as intervention is needed. In terms of the motivational concepts discussed above, from the beginning of the intervention until its successful completion, the process should strive to stimulate feelings of self-determination, competence, and interpersonal relatedness. Finally, the intervention should focus on intrinsic motivation as an outcome objective. That is, the process should nurture the type of ongoing intrinsic motivation that results in the youngster engaging in activities away from the intervention setting that facilitate maintenance and generalization of problem solving behavior.

School Program Changes to Deal with Reactive Misbehavior

A student who perceives school personnel and activities as threats to self-determination, competence, and sense of relatedness to others may react in protective ways. For instance, a student who expects to do poorly on an assigned classroom task may misbehave as a way of protesting and avoiding the activity (Brehm & Brehm, 1981; Kaplan, 1980). If the teacher's reaction to the misbehavior is to threaten or apply punitive measures, the student may react in increasingly negative ways. The case of David provides an example.

> Because of his many experiences of failure at school, David tends to perceive learning situations as threatening. Even before he knows much about a task, he expects to have difficulty coping. Thus, he feels vulnerable, fearful, and sometimes angry at being pushed into such situations. He would like to avoid them, and if he can't do so directly, he tries indirect ways, such as diverting the teacher to a discussion of other matters. When he can't manipulate the situation effectively, he engages in various acting out behaviors, such as arguing, inciting the class to disruption, or regularly missing school. This often leads to a power struggle with the teacher, which ends up with David sent to the principal or home. After a number of such experiences, he has developed rather strong negative expectations and attitudes about school and teachers and has learned a rather large range of behaviors to protect himself from what he perceives as bad situations. Unfortunately, the more he displays such behavior, the more those around him tend to think of him as uncontrollable and incorrigible.

A great deal of negative behavior by students such as David may reflect reactions to immediate school pressures. Those with long or intense histories of school problems may develop general expectations that most classroom experiences are hurtful. Given this expectation, a student may approach all classroom situations looking for the worst and thus perceiving it. Even when a teacher offers "exciting" new opportunities, the student may not perceive them as such.

If the intention is to address the motivational underpinnings for reactive misbehavior, two intervention process objectives seem fundamental: (1) to minimize external demands to perform and conform (e.g., eliminate threats) and (2) to explore learning activities with the student to identify which would be nonthreatening and interesting replacements (e.g., establish a program of intrinsically motivated activity). To these ends, intervention focuses first on assessing (if feasible) the nature of any perceived threats. Such an assessment is guided by motivational thinking about threats to perceived self-determination, competence, and relatedness. The data are then used to replace threatening situations and tasks with activity that produces positive perceptions with respect to identified psychological needs. Even if the specific areas of threat cannot be assessed, one can proceed to work with the student to eliminate and replace aspects of the program against which the student appears to be reacting.

In making changes, it is important to realize that students with extremely negative perceptions of teachers and school programs are not likely to be open to "new" activities that look like "the same old thing." There have to be vivid variations in alternatives offered for students to perceive differences. Several key elements of such interventions are summarized after the following discussion of proactive misbehavior.

School Program Changes to Deal with Proactive Misbehavior

Proactive misbehavior is aimed at directly producing feelings of satisfaction. That is, noncooperative, disruptive, and aggressive behavior may be rewarding or satisfying to an individual because the behavior itself is exciting or because the behavior leads to desired outcomes (e.g., peer recognition, feelings of autonomy and/or competence). Intentional negative behavior stemming from such approach motivation can be viewed as the direct pursuit of deviance.

In practice, it is not easy to differentiate reactive and proactive misbehavior. For example, one student may proactively engage in decorating school walls with graffiti because he or she finds it to be an interesting and exciting act; another may engage in the activity because of norms established by a valued peer group. Still another may reactively engage in such behavior because of anger toward school authorities. (Subsequently, this last student may fall in with negative role models, such as gang members, and adopt their pattern of proactive misbehavior, e.g., delinquent acts that are intrinsically interesting and exciting). And, of course, students involved in deviant behavior inevitably come into conflict with school authorities and soon manifest additional reactive misbehavior.

Proactive misbehavior, such as staying home to watch TV or hang out with friends, participating with gangs, using drugs, and baiting authority, may be much more interesting and exciting to some students than any activity schools offer. That is probably why proactive misbehavior is so difficult to alter. From the perspective of intrinsic motivation theory, the fundamental objective of intervention in such cases is to establish a program of intrinsically motivated activity powerful enough to compete with the satisfaction gained from the misbehavior. This means the intervener must be able to explore options well beyond the norm in offering nonthreatening and

interesting learning activities to replace the student's current school program. At the same time, because such students are unlikely to give up their pursuit of deviance quickly, it may be necessary, initially, to accommodate a wider range of behavior than typically is accepted in schools. That is, if the intention is to recapture the interest of such students, one may have to increase one's tolerance, for a while, with respect to certain "bad manners" (e.g., some rudeness, some swearing), eccentric mannerisms (e.g., strange clothing and grooming), and temporary nonparticipation.

To be more specific, it may be necessary to begin by exploring a student's (a) topical interests (e.g., sports, rock music, movies and TV shows, computer games, auto mechanics) and (b) desired activities (e.g., working with certain individuals, use of nonstandard materials, special status roles). Such personal interests can be used as a starting point. Discussion and sampling of the area of interest may have to be continued until the student identifies a specific facet that s/he would like to learn more about. Concomitantly, the intervener may have to redefine rules and standards so that limits on behavior are expanded for such students (i.e., certain behaviors are tolerated and not treated as misbehavior). Failure to do so may account for the large proportion of these students who are pushed out or drop out due to constant conflict over misconduct.

The case example of Harry suggests the extremes that may have to be attempted.

> Harry would come to school, but he had no interest in working on what his teachers had planned. He spent much of the time talking to friends and looking for exciting ways to make the time pass. He was frequently in the midst of whatever trouble was occurring in class. He was unresponsive to threats of punishment. He readily accepted suspensions. It seemed clear that unless something dramatic were done he would be expelled from school. Rather than letting the tragedy run its course, it was decided to try an experimental intervention. The teacher set aside time to help Harry identify *one* area of personal interest that he would like to learn more about. After some discussion, he indicated he wanted to be a rock musician and would be interested in learning more about how people got into the field and would like to spend time improving his musical skills. Based on his stated interest, several interesting and realistic activities were identified that he indicated he would pursue, such as writing letters to musicians and agencies, instrument instruction and practice time, and reading relevant publications. It was clear, however, that the one topic and the few activities would not hold his interest all day. Indeed, it was likely that what had been planned would involve him for only 1-2 hours a day. Thus, it was easy to anticipate that he would simply fall into his pattern of misbehaving for the remainder of the day, and the experimental effort to counter his misbehavior by building an intrinsically motivating program would be defeated. The solution devised for this problem was as simple as it was controversial. Harry was scheduled to come to school only for that period of time during which he had planned a program he intended to pursue. The reasoning for this approach was twofold: (1) it is clear that students such as Harry only work when they are working on what they have identified

as desirable, and (2) they not only waste the rest of the time, they use it to pursue deviant behavior. If they are not at school a full day, they are less likely to get into as much trouble at school. But, more important, the less that school personnel are in the position of coercing and punishing them, the less likely the problem will be confounded by misbehavior that is a reaction to such practices. Moreover, when such students no longer are expending energy in misbehaving, they are in a better position to work with the teacher to evolve an increasing range of academic interests. Indeed, it was a matter of only a few weeks before Harry indicated several additional areas of interest, including a desire to improve his reading. To accommodate his interests, his school day was expanded. Within a period of several months, he was regularly attending school all day, pursuing a combination of personally designated areas of interest and an increasing amount of the basic curriculum.

Clearly, there are many practical, economic, and legal problems involved in strategies such as cutting back on the length of a student's school day. However, these problems can be considered in the context of the costs to society and individuals of ignoring the fact that forcing certain students to be at school all day interferes with correcting their problems. It may be judged better to have a student's time at school temporarily reduced for positive reasons rather than as punishment (e.g., suspensions) or because of truancy. For older students, of course, a shortened day paired with a part-time job or apprenticeship already is an accepted and often productive strategy.

Focus of Interventions for Dealing with Misbehavior

I. Preventing Misbehavior

A. Expand Social Programs
   1. Increase economic opportunity for low income groups
   2. Augment health and safety prevention and maintenance (encompassing parent education and direct child services)
   3. Extend quality day care and early education

B. Improve Schooling
   1. Personalize classroom instruction (e.g., accommodating a wide range of motivational and developmental differences)
   2. Provide status opportunities for nonpopular students (e.g., special roles as assistants and tutors)
   3. Identify and remedy skill deficiencies early

C. Follow-up All Occurrences of Misbehavior to Remedy Causes
   1. Identify underlying motivation for misbehavior
   2. For unintentional misbehavior, strengthen coping skills (e.g., social skills, problem solving strategies)
   3. If misbehavior is intentional but reactive, work to eliminate conditions that produce reactions (e.g., conditions that make the student feel incompetent, controlled, or unrelated to significant others)
   4. For proactive misbehavior, offer appropriate and attractive alternative ways the student can pursue a sense of competence, control, and relatedness
   5. Equip the individual with acceptable steps to take instead of misbehaving (e.g., options to withdraw from a situation or to try relaxation techniques)
   6. Enhance the individual's motivation and skills for overcoming behavior problems (including altering negative attitudes toward school)

II. Anticipating Misbehavior

A. Personalize Classroom Structure for High Risk Students
   1. Identify underlying motivation for misbehavior
   2. Design curricula to consist primarily of activities that are a good match with the identified individual's intrinsic motivation and developmental capability
   3. Provide extra support and direction so the identified individual can cope with difficult situations (including steps that can be taken instead of misbehaving)

B. Develop Consequences for Misbehavior that are Perceived by Students as Logical (i.e., that are perceived by the student as reasonable fair, and nondenigrating reactions which do not reduce one's sense of autonomy)

III. During Misbehavior

A. Try to base response on understanding of underlying motivation (if uncertain, start with assumption the misbehavior is unintentional)

B. Reestablish a calm and safe atmosphere
   1. Use understanding of student's underlying motivation for misbehaving to clarify what occurred (if feasible, involve participants in discussion of events)
   2. Validate each participant's perspective and feelings
   3. Indicate how the matter will be resolved emphasizing use of previously agreed upon logical consequences that have been personalized in keeping with understanding of underlying motivation
   4. If the misbehavior continues, revert to a firm but nonauthoritarian statement indicating it must stop or else the student will have to be suspended
   5. As a last resort use crises back-up resources
      a. If appropriate, ask student's classroom friends to help
      b. Call for help from identified back-up personnel
   6. Throughout the process, keep others calm by dealing with the situation with a calm and protective demeanor

IV. After Misbehavior

A. Implement Discipline -- Logical Consequences/Punishment
   1. Objectives in using consequences
      a. To deprive student of something s/he wants
      b. To make student experience something s/he doesn't want
   2. Forms of consequences
      a. Removal/deprivation (e.g., loss of privileges, removal from activity)
      b. Reprimands (e.g., public censure)
      c. Reparations (e.g., of damaged or stolen property)
      d. Recantations (e.g., apologies, plans for avoiding future problems)

B. Discuss the Problem with Parents
   1. Explain how they can avoid exacerbating the problem
   2. Mobilize them to work preventively with school

C. Work Toward Prevention of Further Occurrences (see I & II)

SCHOOL AVOIDANCE: REACTIVE AND PROACTIVE

An enhanced conceptual base of the full range of factors causing student problems builds on contemporary motivational theory. School avoidance behavior, like the misbehavior described above, can be understood in terms of students' attempts to act in ways that make them feel in control, competent, and connected with significant others. The action may be overt, such as a direct refusal to attend, or covert, such as passive withdrawal and feigned illness.

The importance of distinguishing the underlying motivation for school avoidance behavior can be illustrated by thinking about three students who are school refusers.

> Although others think Janet is afraid to attend school, in fact her avoidance is motivated by a desire to stay home with her mother. That is, she is proactively seeking to maintain her sense of relatedness with home and family. In contrast, Jeff refuses to attend as a direct protest against school rules and demands because he experiences them as a threat to his sense of self-determination; his avoidance is reactive. Joe's avoidance also is reactive; he lacks the skills to do many of the assigned tasks and becomes so anxious over this threat to his competence that he frequently runs out of the classroom.

Differentiating Among School Avoiders

In a study of school avoiders, Taylor and Adelman (1990) differentiated 5 groups. Of the five, four involve student proactive and reactive motivation; the fifth reflects a variety of needs related to family dynamics and events that may or may not result in a student wanting to avoid school. As with most subgroupings, the categories are not mutually exclusive.

1. *Proactive attraction to alternatives to school.* There are many aspects of a student's life at home and in the community that compete with school. For instance, there are children who miss school primarily because they want to stay home to be with a parent, grandparent, or younger sibling or because they have become hooked on TV programs or other favorite activities. And, of course, among junior and senior high students, there often is a strong pull to hang out with peers (truants and dropouts). From an intrinsic motivational perspective, such proactive attraction can occur because a youngster finds these circumstances produce feelings of relatedness, competence, or control over one's life that are much greater than those experienced at school.

2. *Reactive avoidance of experiences at school that lead to feelings of incompetence or lack of relatedness (including lack of safety).* In contrast to proactive avoidance, reactive avoidance (in its many forms) is to be anticipated whenever a student expects events to be negative and to result in negative feelings. Two specific areas of concern in this respect are events that lead to feelings of incompetence

or lack of relatedness (including lack of safety) in the school context. In particular, it is not surprising that students who expect to encounter significant failure/punishment in their efforts to meet others' or their own academic and social standards come to perceive school as a threatening place. Such expectations may arise not only for individuals who have actual disabilities and skill deficits, but for any student who experiences standards for learning, performance, and behavior that exceed her or his ability. These youngsters report feelings of embarrassment, of being different, of not being liked, of being left out, of being abused. Some avoid school whenever kickball is on the schedule because they know no one wants them on their team. Some refuse to attend because another student has singled them out to bully. And there are some who have moved to a new school and find they are not accepted by the peer group with whom they identify.

3. *Reactive avoidance to control by others at school.* When one feels that others are exerting inappropriate control, there may be a psychological reaction that motivates efforts to restore one's feeling of self-determination. There are a significant number of instances where school avoidance is an expression of a power struggle between teacher and student or parent and child. The more the teacher or parent tightens the limits and punishes the individual, the more the youngster seems committed to showing s/he can't be controlled. Some adopt the idea of refusing to go to school. In such cases, the more the parents threaten, take away privileges, and punish, the more the child's determination grows. The struggle often becomes a literal wrestling match to get a resistant child from the bed, into clothes, out to the car, and finally through the classroom door. Some parents and teachers end up winning a particular battle, but they usually find the struggle for control continues on many other fronts.

4. *Reactive avoidance in response to overwhelming anxiety/fear.* Although they represent a minority of the many youngsters who avoid school, for some individuals the term "phobic" is appropriate. Again, in some instances, the extreme anxiety/fear may be a reaction to expectations about finding oneself in circumstances where one will feel incompetent, lacking control, or loss (separation) or lack of relatedness to significant others. In true phobias, however, even the student's assessment of objective reality does not match his or her high degree of anxiety and fear. Such students report pervasive symptoms (e.g., sleeping problems, anxiety produced vomiting, uncontrollable crying). In addition, not uncommonly they have parents who themselves report strong fears and phobic behaviors. Even with extensive accommodations by teachers and parents, the fears of these students often continue to interfere with attending school, thus requiring major therapeutic intervention.

5. *Needs related to family members and events.* Parents have a number of reasons for keeping their youngsters home from school. For

> instance, some students are frequently absent because they have to babysit with younger siblings or be with ailing or lonely parents or grandparents. Crises in the home, such as death, divorce, or serious illness, can cause parents to keep their children close at hand for comfort and support. Under such circumstances, some youngsters are attracted to the opportunity to stay home to meet a parent's special needs or become frightened that something bad will happen to a family member when they are at school. Moreover, when life at home is in turmoil, students may feel they cannot bear the added pressure of going to school. Thus, crises at home, and a variety of other underlying family dynamics, can produce emotions in a youngster that lead to motivation for avoiding school.

Unfortunately, whatever the initial cause of nonattendance, the absences become a problem unto themselves. Of specific consequence is the fact that students quickly fall behind in their school work; grades plummet; there is a mounting sense of hopelessness and increased avoidance. Among adolescents, increasing avoidance can transition rapidly into dropping out of school.

As a note of caution, it is also important to alert staff to the fact that not all school avoidance stems from psychoeducational causes. For example, in one school avoidance case, the student complained of stomach pain. The parents, counselor, school nurse, school psychologist, and the student herself assumed this simply was a physical symptom of anxiety related to pressure at school. However, the school nurse insisted on a thorough physical examination that found the pain was a pre-ulcer symptom. Medication controlled the symptom, and regular school attendance resumed.

Intervention Overview

Work with school avoidance cases involves four facets: assessment, consultation with parents, consultation with teachers, and counseling with students and their families. Understanding school avoidance from the perspective of the type of motivational ideas discussed above profoundly influences the approach to each of these tasks. The following examples are illustrative.

Corrective Interventions. In general, motivationally-oriented analyses of school avoidance allow interveners to offer parents, teachers, and the student an intervention responsive to the motivational underpinnings of school avoidance behavior. For instance, based on motivational data, parents and teachers can be helped to facilitate environment and program changes that account for a youngster's need to feel self-determining, competent, and related. Such changes may include (a) identifying activity options to attract a proactive school avoider, (b) eliminating situations leading to reactive avoidance, and (c) establishing alternative ways for a student to cope with circumstances that cannot be changed. In counseling students, first focus on the individual's underlying motivation for avoidance (e.g., factors instigating, energizing, directing, and maintaining the motivation), explore motivation for change, clarify available alternatives with the student and significant others, and then facilitate action. It should be stressed that a motivational orientation does not supplant a focus on skill development and remediation. Rather, it places skill instruction in a motivational

context and highlights the importance of systematically addressing motivational considerations in order to maximize skill development.

More specifically, the intervention focus for students behaving *reactively*, includes reducing reactance and enhancing positive motivation for attending school. That is, the fundamental enabling (process) objectives are (1) minimizing external demands for performing and conforming (e.g., eliminating threats) and (2) exploring with the student ways to add activities that would be nonthreatening and interesting (e.g., establishing program the majority of which emphasizes intrinsically motivating activities). For example, if Joe is concerned about an inability to handle assignments, steps are taken to match assignments to his current capabilities and provide help that minimizes failure and remedies deficits handicapping progress. If the problem stems from lack of interest in the current school program, the focus is on increasing the attractiveness of school by finding or creating new activities and special roles. If the avoidance truly is a phobic reaction, ongoing family counseling is indicated, as is extensive school consultation in pursuit of the type of expanded accommodation and support the student needs.

For youngsters whose avoidance is *proactively* motivated, staying home to watch TV or to hang out with friends, running around with gangs, and participating in the drug culture can be much more interesting and exciting than usual school offerings. This probably accounts for why proactive school avoidance can be so difficult to counter. Fundamentally, the objectives in trying to counter proactively motivated avoidance involve exploring and agreeing upon a program of *intrinsically* motivating activity to replace the student's current school program. The new program must be able to produce greater feelings of self-determination, competence, and relatedness than the activity that has pulled the youngster away from school. To these ends, alternatives must be nonthreatening and interesting and often will have to differ markedly from those commonly offered. For instance, such students may be most responsive to changes in program content that emphasize their contemporary culture (e.g., sports, rock music, movies and TV shows, computer games, auto mechanics, local events), processes that deemphasize formal schooling (e.g., peer tutoring, use of nonstandard materials), and opportunities to assume special, positive role status (e.g., as a student official, office monitor, paid cafeteria worker). Such personalized options and opportunities usually are essential starting points in overcoming proactive avoidance.

Starting or returning: the crucial transition phase. As avoiders are mobilized to start or return to school, it is critical to ensure the entry transition phase is positive. For instance, it is sometimes necessary to plan on only a partial school day schedule. This occurs when it is concluded that full day attendance would be counterproductive to enhancing intrinsic motivation for school.

It also is critical not to undermine a new or returning student's emerging hope about feeling accepted, in control, and competent at school. Such students tend to be skeptical and fearful about whether they will fit in and be accepted. Often their worst fears come true. Two system characteristics commonly found to work against successful entry for school avoiders are (1) lack of a receptive atmosphere and (2) lack of special accommodation.

It seems obvious that school avoiders need to feel welcomed when enrolling in or returning to school. Yet, students and parents often report negative encounters in

dealing with attendance office procedures, personnel who are unaware of the problem and special entry plans, and students and staff who appear hostile to the plans that have been made.

To counter such negative experiences, a key strategy is to arrange for one or more on-site advocates who increase the likelihood of a welcoming atmosphere by greeting the student and guiding her or him through the transition phase. One such advocate needs to be a professional on the school staff who will provide procedural help (with attendance and new schedules) and who can sensitize key personnel and students to the importance of a positive reception. A student advocate or peer counselor also is desirable if an appropriate one can be found.

It also must be recognized that many proactive and reactive avoiders, upon first entering or returning to school, do not readily fit in. This is especially true of those whose pattern of deviant and devious behavior contributed to school avoidance in the first place. For such students, teachers must not only be willing to offer attractive and nonthreatening program alternatives, they must be willing temporarily to structure wider limits than most students typically are allowed.

SUMMING UP

The paradox in intervening with students who misbehave or avoid school is that they are unlikely to approach the process positively or even neutrally. Thus, in order to work with such students, first the intervener must be able to enhance the youngster's motivational readiness. Then, the process must maintain and even further enhance that motivation. In terms of the motivational concepts discussed above, this means striving to stimulate in the youngster feelings of self-determination, competence, and interpersonal relatedness. Furthermore, the process should focus on intrinsic motivation as an outcome objective. That is, it should nurture the type of ongoing intrinsic motivation that results in the youngster developing and maintaining positive behavior, even after the special intervention terminates.

Similarly, because such students tend to have extremely negative perceptions of teachers and school tasks, they are unlikely to respond to program changes that look like "the same old thing." Exceptional efforts must be made so that these students will come to view the school as supportive (rather than hostile and controlling or indifferent) and perceive content, outcome, and activity options as personally valuable and obtainable. To these ends, schools must be prepared to implement a variety of learning options, and a structure that facilitates the student's exploration and decision making with respect to which options to pursue. The structure also must provide ongoing support, guidance, and information about progress in response to student requests and allow for student-initiated changes in program plans.

Options. Provision of a range of potentially valued and feasible options for the student to choose from allows the intervener to identify activities that are a good match with the student's intrinsic motivation. (By definition, a good match means the activities are not threatening.) In extreme cases, it may be necessary to deemphasize temporarily the standard curriculum and pursue only activities to which the student makes a personal commitment.

Student decision making. From a motivational perspective, one of the most basic concerns is student involvement in decision making about daily school activities and consequences for misbehavior. For one thing, people who are not included in decision making often have little commitment to what is decided. And, people who perceive themselves as being coerced to do something they don't want to do often react by avoiding in an effort to regain their sense of self-determination. Thus, decision-making processes that maximize student perceptions of having made a desirable choice are essential to interventions addressing the motivational underpinnings.

Continuous information on functioning. Great care must be taken to guard against the potential negative impact of overemphasizing surveillance and over relying on extrinsics in countering avoidance and in providing feedback on progress. Information given must highlight success not only in terms of attending school but with respect to the student's effectiveness in making good decisions and on the relationship of outcomes to the student's intrinsic reasons for attending. Feedback, of course, also must clarify directions for future progress. Handled well, the information should contribute to, rather than undermine, the student's feelings of competence, self-determination, and relatedness.

From a preventive perspective, understanding underlying motivation suggests the need for general social and school program changes. In motivational terms, the aims of such changes are to (a) prevent and overcome negative attitudes toward school and learning, (b) enhance motivational readiness for learning and overcoming problems that arise, and (c) expand and maintain intrinsic motivation for learning and problem solving processes. Preliminary work suggests that contemporary thinking about motivation (especially intrinsic motivation) offers important implications for the prevention and correction of school misbehavior and avoidance.

Finally, the types of intervention outlined throughout this presentation require significant system changes in thinking and practice related to schooling. Organizational change does not come easy. It is hard and often disappointing work. Progress can be slow and frustrating to achieve. Nevertheless, it is clear from the literature on organizational change in schools that significant change is feasible. Transactions must establish a collaborative, problem solving partnership based on a shared appreciation for the problem of school misbehavior and avoidance and their correction.

SOME RELATED REFERENCES

Adelman, H.S., & Taylor, L. (1993). *Learning problems and learning disabilities: Moving Forward.* Pacific Groves, CA: Brooks/Cole.

Atkinson, L., Quarrington, B., Cyr, J.J. (1985). School refusal: The heterogeneity of a concept. *American Journal of Orthopsychiatry, 55*, 83-101.

Brehm, S.S., & Brehm, J.W. (1981). *Psychological reactance: A theory of freedom and control.* New York: Academic Press.

Charles, C.M. (1985). *Building classroom discipline: From models to practice* (2nd ed.). New York: Longman.

Cooper, M. (1986). A model of persistent school absenteeism. *Education Researcher, 28*, 14-20.

Deci, E.L., & Ryan, R.M. (1985). *Intrinsic motivation and self-determination in human behavior.* New York: Plenum Press.

Dreikurs, R., Grunwald, B.B., & Pepper, F.C. (1982). *Maintaining sanity in the classroom: Classroom management techniques* (2nd ed.). New York: Harper & Row.

Ferrari, M. (1986). Fears and phobias in childhood: Some clinical and developmental considerations. *Child Psychiatry and Human Development, 17*, 75-87.

Hersov, L. (1985). School refusal. In M. Rutter & L. Hersov (Eds.), *Child and adolescent psychiatry.* Oxford: Blackwell.

Hersov, L. & Berg, I. (Eds.) (1980). *Out of school: Modern perspectives in truancy and school refusal.* Chichester: John Wiley & Sons.

Hyman, I., Flanagan, D., & Smith, K. (1982). Discipline in the schools. In C.R. Reynolds & T.B. Gutkin (Eds.), *The handbook of school psychology* (pp. 454-480). New York: Wiley.

Kahn, J.H., Nursten, J.P., & Carroll, H.C.M. (1981). *Unwillingly to school -- School phobia or school refusal: A psychosocial problem.* Oxford: Pergamon.

Kaplan, H.B. (1980). *Deviant behavior in defense of self.* New York:

Knoff, H.M. (1987). School-based interventions for discipline problems. In C.A. Maher & J.E. Zins (Eds.), *Psychoeducational interventions in the schools* (pp. 118-140). New York: Pergamon.

Maher, C.A., & Zins, J.E. (Eds.). (1987). *Psychoeducational interventions in the schools* (pp. 118-140). New York: Pergamon.

Millman, H.L., Schaefer, C.E., & Cohen, J.J. (1981). *Therapies for school behavior problems.* San Francisco: Jossey-Bass.

Taylor, L., & Adelman, H.S. (1990). School avoidance behavior: Motivational bases and implications for intervention. *Child Psychiatry and Human Development, 20,* 219-233.

Tisher, M. (1983). School refusal: A depressive equivalent. In D.P. Cantwell & G.A. Carlson (Eds.), Affective disorders in childhood. New York: Spectrum Pub.

Wolfgang, C.H., & Glickman, C.D. (1986). *Solving discipline problems: Strategies for classroom teachers* (2nd ed.). Boston: Allyn & Bacon.

ADDRESSING BARRIERS TO LEARNING: NEW DIRECTIONS FOR MENTAL HEALTH IN SCHOOLS

Unit III

Working With Others to Enhance Programs and Resources

Sections

A. Working Relationships

B. Working to Enhance Existing Programs

C. Building a Comprehensive, Integrated Approach at Your School

We must indeed all hang together,
or most assuredly we shall
all hang separately.

Benjamin Franklin

This unit is one of a set of three focused on the role of schools in addressing psychosocial and mental health problems that interfere with students' learning and performance.

Professionals devote a great deal of time and energy learning to carry out individual duties with competence. However, it is becoming increasingly evident that the type of comprehensive, integrated approach needed to address barriers to student learning requires systemic changes and programmatic approaches that transcend what individuals can do by themselves.

In general, enhancing services and programs requires a focus on policy change and improving systems of care. The goals are to improve availability, access, coordination, integration, and comprehensiveness. For individual clients, this means developing integrated systems to identify, assess, triage, monitor, manage, and evaluate care. For schools, it means developing integrated systems to map, analyze, and redeploy resources and to outreach to the surrounding community to encourage involvement and assistance.

None of this is likely to happen, of course, in the absence of staff development that fosters capacity building for dealing with mental health and psychosocial problems through new ways to work collaboratively. This is the focus of this unit.

At the very foundation of all this is working together with others in effective ways.

ADDRESSING BARRIERS TO LEARNING: NEW DIRECTIONS FOR MENTAL HEALTH IN SCHOOLS

Contents of All Three Units

I. Placing Mental Health into the Context of Schools and the 21st Century

A. Introductory Overview
B. The Need to Enhance Healthy Development and Address Barriers to Learning
C. Addressing the Need: Moving Toward a Comprehensive Approach
Coda: A Wide Range of Responses for a Wide Range of Problems

II. Mental Health Services & Instruction: What a School Can Do

A. Screening and Assessment
B. Problem Response and Prevention
C. Consent, Due Process, and Confidentiality
Coda: Networks of Care
Follow-Up Reading
•*ABCs of Assessment*
•*Managing and Preventing School Misbehavior and School Avoidance*

III. Working with Others to Enhance Programs and Resources

A. Working Relationships

Differences as a Problem
Differences as a Barrier
Overcoming Barriers Related to Differences
Building Rapport and Connection
One Other Observation

B. Working to Enhance Existing Programs

It's Not About Collaboration. It's About Being Effective
A Team to Manage Care
A Team to Manage Resources

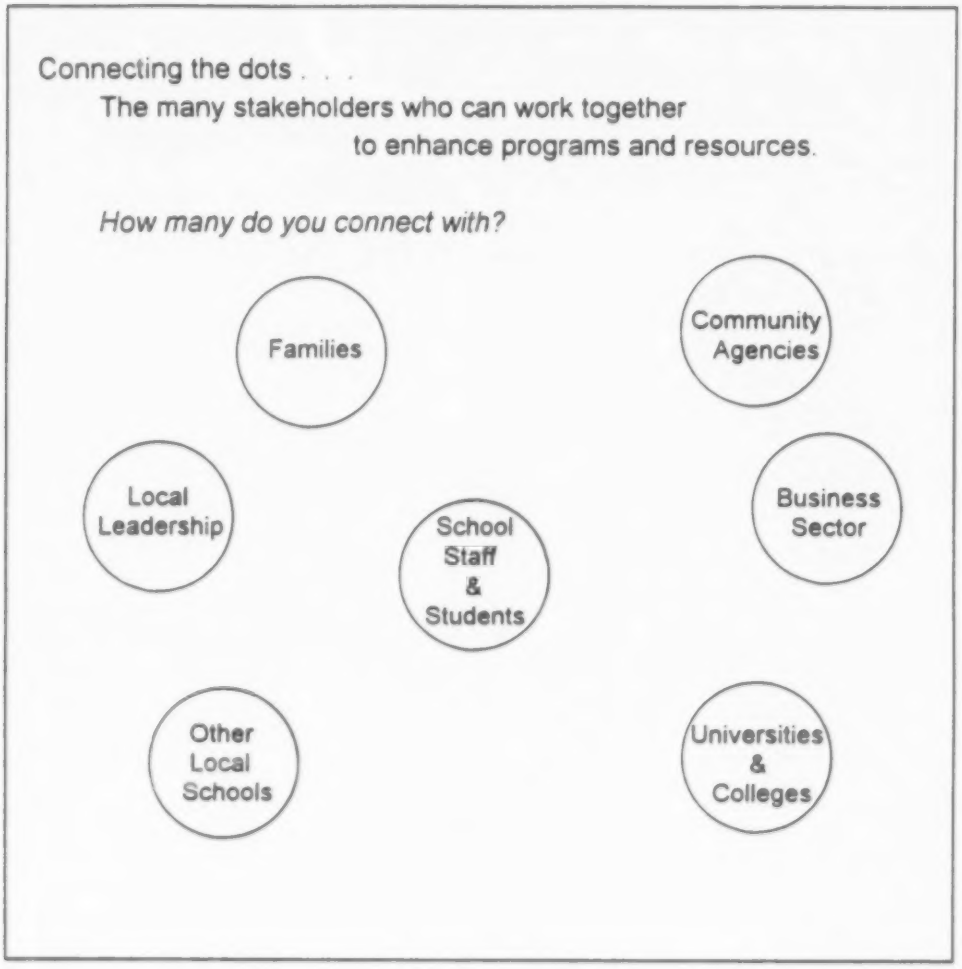
C. Building a Comprehensive, Integrated Approach at Your School

Classroom-Focused Enabling
Crisis Assistance and Prevention
Support for Transitions
Student and Family Assistance
Home Involvement in Schooling
Community Outreach for Involvement and Support (including a focus on volunteers)

Coda: New Roles for Schools: A Multifaceted Focus

Glossary of Key Terms, Acronyms, and Laws

Section A: *Working Relationships*



Contents:

Differences as a Problem
Differences as a Barrier
Overcoming Barriers Related to Differences
Building Rapport and Connection
One Other Observation

BEST COPY AVAILABLE

Objectives for Section A

After completing this section of the unit, you should be able to:

- identify at least three necessary ingredients in building positive working relationships

- identify at least three cultural competence values.

A Few Focusing Questions

- *What types of differences might interfere with working relationships?*

- *How can barriers to working relationships be overcome?*

- *What is role might cultural competence and cultural values play in enhancing working relationships?*

Treat people as if they were
what they ought to be
and you help them become
what they are capable of being.

Goethe

In pursuing mental health functions, a school's staff must be sensitive to a variety of human, community, and institutional differences and learn strategies for dealing with them.

With respect to working with students and their parents, staff members encounter differences in

- sociocultural and economic background and current lifestyle
- primary language spoken
- skin color
- sex
- motivation for help

and much more.

Comparable differences are found in working with school personnel (certificated and non certificated, line staff and administrators).

In addition, there are differences related to power, status, and orientation.

And, for many newcomers to a school, the culture of schools in general and that of a specific school and community may differ greatly from other settings where they have lived and worked.

Differences as a Problem

For school staff, existing differences may make it difficult to establish effective working relationships with students and others who effect the student.

> For example, many schools do not have staff who can reach out to students whose primary language is Spanish, Korean, Tagalog, Vietnamese, Cambodian, Armenian, and so forth.

And although workshops and presentations are offered in an effort to increase specific cultural awareness, what can be learned in this way is limited, especially when one is in a school of many cultures.

> There also is a danger in prejudgments based on apparent cultural awareness. There are many reports of students who have been victimized by professionals who are so sensitized to cultural differences that they treat fourth generation Americans as if they had just migrated from their cultural homeland.

Obviously, it is desirable to hire staff who have the needed language skills and cultural awareness and who do not rush to prejudge.

> Given the realities of budgets and staff recruitment, however, schools cannot hire a separate specialist for all the major language, cultural, and skin color differences that exist in some schools.

Nevertheless, the objectives of accounting for relevant differences while respecting individuality can be appreciated and addressed.

Examples of Client Differences as a Problem

"A 14 year old Filipino wanted help, but his mother told me her culture doesn't recognize the need for counseling."

"Despite the parents' resistance to accepting the need for treatment, we decided the student had to be sent to the emergency room after the suicide attempt."

"A 15 year old Vietnamese attempted suicide because her parents were forcing her into an arranged marriage."

"An 18 year old Latina student reported suicidal ideation; she expressed extreme resentment toward her father for being so strict that he would not allow her to date."

As these cases illustrate, differences can result in problems for students, parents, and staff. Although such problems are not easily resolved, they are solvable as long as everyone works in the best interests of the student, and the differences are not allowed to become barriers to relating with others.

BEST COPY AVAILABLE

Differences as a Barrier

"You don't know what it's like to be poor."

"You're the wrong color to understand."

"You're being culturally insensitive."

"How can a woman understand a male student's problems?"

"Male therapists shouldn't work with girls who have been sexually abused."

"I never feel that young professionals can be trusted."

"Social workers (nurses/MDs/ psychologists/teachers) don't have the right training to help these kids."

"How can you expect to work effectively with school personnel when you understand so little about the culture of schools and are so negative toward them and the people who staff them?"

"If you haven't had alcohol or other drug problems, you can't help students with such problems."

"If you don't have teenagers at home, you can't really understand them."

"You don't like sports! How can you expect to relate to teenagers?"

You know, it's a tragedy in a way that Americans are brought up to think that they cannot feel for other people and other beings just because they are different.
Alice Walker

As part of a working relationship, differences can be complementary and helpful -- as when staff from different disciplines work with and learn from each other.

> Differences become a barrier to establishing effective working relationships when negative attitudes are allowed to prevail. Interpersonally, the result generally is conflict and poor communication.

For example, differences in status, skin color, power, orientation, and so forth can cause one or more persons to enter the situation with negative (including competitive) feelings. And such feelings often motivate conflict.

> Many individuals (students, staff) who have been treated unfairly, been discriminated against, been deprived of opportunity and status at school, on the job, and in society use whatever means they can to seek redress and sometimes to strike back. Such an individual may promote conflict in hopes of correcting power imbalances or at least to call attention to a problem.

Often, however, power differentials are so institutionalized that individual action has little impact.

> It is hard and frustrating to fight an institution.

It is much easier and immediately satisfying to fight with other individuals one sees as representing that institution.

> However, when this occurs where individuals are supposed to work together, those with negative feelings may act and say things in ways that produce significant barriers to establishing a working relationship. Often, the underlying message is "you don't understand," or worse yet "you probably don't want to understand." Or, even worse, "you are my enemy."

It is unfortunate when such barriers arise between students and those trying to help them; it is a travesty when such barriers interfere with the helpers working together effectively. Staff conflicts detract from accomplishing goals and contribute in a major way to "burn out."

Overcoming Barriers Related to Differences

When the problem is **only** one of poor skills, it is relatively easy to overcome. Most motivated professionals can be directly taught ways to improve communication and avoid or resolve conflicts that interfere with working relationships.

There are, however, no easy solutions to overcoming deeply embedded negative attitudes. Certainly, a first step is to understand that the nature of the problem is not differences per se but negative perceptions stemming from the politics and psychology of the situation.

It is these perceptions that lead to

(1) prejudgments that a person is bad because of an observed difference

and

(2) the view that there is little to be gained from working with that person.

Thus, minimally, the task of overcoming negative attitudes interfering with a particular working relationship is twofold.

To find ways

(1) to counter negative prejudgments (e.g., to establish the credibility of those who have been prejudged)

and

(2) to demonstrate there is something of value to be gained from working together.

Building Rapport and Connection

To be effective in working with another person (student, parent, staff), you need to build a positive relationship around the **tasks** at hand.

Necessary ingredients in building a working relationship are

* minimizing negative prejudgments about those with whom you will be working
* taking time to make connections
* identifying what will be gained from the collaboration in terms of mutually desired outcomes -- to clarify the value of working together
* enhancing expectations that the working relationship will be productive -- important here is establishing credibility with each other
* establishing a structure that provides support and guidance to aid task focus
* periodic reminders of the positive outcomes that have resulted from working together

With specific respect to **building relationships** and **effective communication**, three things you can do are:

* convey empathy and warmth (e.g., the ability to understand and appreciate what the individual is thinking and feeling and to transmit a sense of liking)
* convey genuine regard and respect (e.g., the ability to transmit real interest and to interact in a way that enables the individual to maintain a feeling of integrity and personal control)
* talk with, not at, others -- active listening and dialogue (e.g., being a good listener, not being judgmental, not prying, sharing your experiences as appropriate and needed)

Finally, watch out for ego-oriented behavior (yours and theirs) -- it tends to get in the way of accomplishing the task at hand.

Accounting for Cultural, Racial, and Other Significant Individual and Group Differences

All interventions to address barriers to learning and promote healthy development must consider significant individual and group differences.

In this respect, discussions of diversity and cultural competence offer some useful concerns to consider and explore. For example, the Family and Youth Services Bureau of the U.S. Department of Health and Human Services, in a 1994 document entitled *A Guide to Enhancing the Cultural Competence of Runaway and Homeless Youth Programs*, outlines some baseline assumptions which can be broadened to read as follows:

Those who work with youngsters and their families can better meet the needs of their target population by enhancing their competence with respect to the group and its intragroup differences.

Developing such competence is a dynamic, on-going process -- not a goal or outcome. That is, there is no single activity or event that will enhance such competence. In fact, use of a single activity reinforces a false sense of that the "problem is solved."

Diversity training is widely viewed as important, but is not effective in isolation. Programs should avoid the "quick fix" theory of providing training without follow-up or more concrete management and programmatic changes.

Hiring staff from the same background as the target population does not necessarily ensure the provision of appropriate services, especially if those staff are not in decision-making positions, *or* are not themselves appreciative of, or respectful to, group and intragroup differences.

Establishing a process for enhancing a program's competence with respect to group and intragroup differences is an opportunity for positive organizational and individual growth.

(cont.)

The Bureau document goes on to state that programs:

> are moving from the individually-focused "medical model" to a clearer understanding of the many external causes of our social problems ... why young people growing up in intergenerational poverty amidst decaying buildings and failing inner-city infrastructures are likely to respond in rage or despair. It is no longer surprising that lesbian and gay youth growing up in communities that do not acknowledge their existence might surrender to suicide in greater numbers than their peers. We are beginning to accept that social problems are indeed more often the problems of society than the individual.
>
> These changes, however, have not occurred without some resistance and backlash, nor are they universal. Racism, bigotry, sexism, religious discrimination, homophobia, and lack of sensitivity to the needs of special populations continue to affect the lives of each new generation. Powerful leaders and organizations throughout the country continue to promote the exclusion of people who are "different," resulting in the disabling by-products of hatred, fear, and unrealized potential.
>
> ... We will not move toward diversity until we promote inclusion ... Programs will not accomplish any of (their) central missions unless ... (their approach reflects) knowledge, sensitivity, and a willingness to learn.

In their discussion of "The Cultural Competence Model," Mason, Benjamin, and Lewis* outline five cultural competence values which they stress are more concerned with behavior than awareness and sensitivity and should be reflected in staff attitude and practice and the organization's policy and structure. In essence, these five values are

(1) *Valuing Diversity* -- which they suggest is a matter of framing cultural diversity as a strength in clients, line staff, administrative personnel, board membership, and volunteers.

(2) Conducting Cultural Self-Assessment -- to be aware of cultural blind spots and ways in which one's values and assumptions may differ from those held by clients.

(3) *Understanding the Dynamics of Difference* -- which they see as the ability to understand what happens when people of different cultural backgrounds interact.

(4) *Incorporating Cultural Knowledge* -- seen as an ongoing process.

(5) *Adapting to Diversity* -- described as modifying direct interventions and the way the organization is run to reflect the contextual realities of a given catchment area and the sociopolitical forces that may have shaped those who live in the area..

*In *Families and the Mental Health System for Children and Adolescence*, edited by C.A. Heflinger & C.T. Nixon (1996). CA: Sage Publications.

STOP. THINK. DISCUSS

In most situations, direct or indirect accusations that *"You don't understand"* are valid. Indeed, they are givens. After all, it is usually the case that one does not fully understand complex situations or what others have experienced and are feeling.

With respect to efforts to build working relationships, accusing someone of not understanding tends to create major barriers. This is not surprising since the intent of such accusations generally is to make others uncomfortable and put them on the defensive. It is hard to build positive connections with a defensive person. Avoidance of *"You don't understand"* accusations may be a productive way to reduce at least one set of major barriers to establishing working relationships.

At this point, what are you ideas about how to maximize good working relationships at your school?

One Other Observation

Finally, it is essential to remember that **individual differences** are the most fundamental determinant of whether a good relationship is established. This point was poignantly illustrated by the recent experience of the staff at one school.

A Korean student who had been in the U.S.A. for several years and spoke comprehensible English came to the center seeking mental health help for a personal problem. The center's policy was to assign Korean students to Asian counselors whenever feasible. The student was so assigned, met with the counselor, but did not bring up his personal problem. This also happened at the second session, and then the student stopped coming.

In a follow-up interview conducted by a nonAsian staff member, the student explained that the idea of telling his personal problems to another Asian was too embarrassing.

Then, why had he come in the first place?

Well, when he signed up, he did not understand he would be assigned to an Asian; indeed, he had expected to work with the "blue-eyed counselor" a friend had told him about.

BEST COPY AVAILABLE

A Few References Related to Working Relationships

J.K. Brilhart & G.J. Galanes (1995). *Effective Group Discussion* (8th ed.). Madison, WI: WCB Brown & Benchmark.

J.L. Epstein (1995). School/Family/Community Partnerships: Caring for the Children We Share. *Phi Delta Kappan, 76*, 701-713.

K. Hooper-Briar & H.A. Lawson (1994) *Serving children, Youth and Families Through Interprofessional Collaboration and Service Integration: A Framework for Action.* Oxford, OH: Danforth Foundation and the Institute for Educational Renewal at Miami University.

K. Hooper-Briar & H.A. Lawson (Eds.) (1996). *Expanding Partnerships for Vulnerable Children, Youth, and Families.* Alexandria, VA: Council on Social Work Education.

A. Melaville & M. Blank (1991). *What It Takes: Structuring Interagency Partnerships to Connect Children and Families with Comprehensive Services.* Washington, D.C.: Education and Human Services Consortium.

F. Rees (1993). *25 Activities for Teams.* San Diego CA: Pfeiffer & Co.

L. Rosenblum, M.B. DiCecco, L. Taylor, & H.S. Adelman (1995). Upgrading school support programs through collaboration: Resource Coordinating Teams. *Social Work in Education, 17*, 117-124.

S.A. Rosenfield & T.A. Gravois (1996). *Instructional Consultation Teams: Collaborating for Change.* New York: Guilford.

Test Questions -- Unit III: Section A

(1) Of the various necessary ingredients in building positive working relationships, list three of those covered in this unit.

_____

_____

_____

(2) Enumerate three of the five cultural competence values as defined by Mason, Benjamin, & Lewis (1996).

_____

_____

_____

(3) There is a danger inherent in making prejudgments based on apparent cultural awareness.

True ____ False____

(4) Poor working relationships arise whenever there are individual, racial, or cultural differences.

True ____ False____

(5) Which of the following are things to do to help build working relationships and effective communication?

____ (a) convey empathy and warmth

____ (b) convey genuine regard and respect

____ (c) talk with, not at, others

____ (d) a & b

____ (e) all the above

Section B: *Working to Enhance Existing Programs*

Contents:

It's Not About Collaboration. It's About Being Effective
A Team to Manage Care
A Team to Manage Resources

BEST COPY AVAILABLE

Objectives for Section B

After completing this section of the unit, you should be able to:

- identify at least two basic tasks for primary managers of care
- identify at least two major functions of a school-based team designed to manage resources

A Few Focusing Questions

- *What is to be gained through collaborating with others at the school and in the community?*
- *What is the difference between monitoring care and managing care?*
- *Why is it important to map and analyze existing resources at a school site?*

BEST COPY AVAILABLE

For any school program to improve, there must be both individual and group efforts. Group efforts may focus on planning, implementation, evaluation, advocacy, and involvement in shared decision making related to policy and resource deployment.

> In working together to enhance existing programs, group members look for ways to improve communication, cooperation, coordination, and integration within and among programs. Through such collaborative efforts, they seek to (a) enhance program availability, access, and management of care, (b) reduce waste stemming from fragmentation and redundancy, (c) redeploy the resources saved, and (d) improve program results.

Formal opportunities for working together at schools often take the form of committees or councils and teams. To be effective, such collaborative efforts require thoughtful and skillful facilitation. Without careful planning and implementation, collaborative efforts rarely can live up to the initial hope. Even when they begin with great enthusiasm, poorly facilitated working sessions quickly degenerate into another ho-hum meeting, more talk but little action, another burden, and a waste of time. This is particularly likely to happen when the emphasis is mainly on the unfocused mandate to "collaborate," rather than on moving an important vision and mission forward through effective working relationships.

STOP. THINK. DISCUSS

Think about the last collaborative meeting you attended.

What was the purpose of the meeting?

How well did the various participants work together?

Did it produce more effective results than would have arisen without a formal collaborative effort?

How might the process have been improved?

It's Not About Collaboration. It's About Being Effective.

Most of us know how hard it is to work effectively with a group. Many staff members at a school site have jobs that allow them to carry out their duties each day in relative isolation of other staff. And despite various frustrations they encounter in doing so, they can see little to be gained through joining up with others. In fact, they often can point to many committees and teams that drained their time and energy to little avail.

> Despite all this, the fact remains that no organization can be truly effective if everyone works in isolation. And it is a simple truth that there is no way for schools to play their role in addressing barriers to student learning and enhancing healthy development if a critical mass of stakeholders do not work together towards a shared vision. There are policies to advocate for, decisions to make, problems to solve, and interventions to plan, implement, and evaluate.

Obviously, true collaboration involves more than meeting and talking. The point is to work together in ways that produce the type of actions that result in effective programs. For this to happen, steps must be taken to ensure that committees, councils, and teams are formed in ways that ensure they can be effective. This includes providing them with the training, time, support, and authority to carry out their role and functions. It is when such matters are ignored that groups find themselves meeting and meeting, but going nowhere.

> There are many committees and teams that those concerned with addressing barriers to learning and promoting healthy development can and should be part of. These include school-site shared decision making bodies, committees that plan programs, teams that review students referred because of problems and that manage care, quality review bodies, and program management teams.

Two key teams are highlighted here because or the essential role they play in enhancing program effectiveness (a) a team to manage client care and (b) a team to manage program and service resources.

Planning and Facilitating Effective Meetings

There are many fine resources that provide guidelines for conducting effective meetings. Some key points are synthesized below.

Forming a Working Group

- There should be a clear statement about the group's mission.
- Be certain that the members agree to pursue the stated mission and, for the most part, share a vision.
- Pick someone who the group will respect and who either already has good facilitation skills or will commit to learning what those that are needed.
- Provide training for members so they understand their role in keeping a meeting on track and turning talk into effective action.
- Be certain to designate processes (a) for sending members information before a meeting regarding what is to be accomplished, specific agenda items, and individual assignments and (b) for maintaining and circulating a record of decisions and planned actions (what, who, when) formulated at the meeting.

Meeting Format

- Be certain there is a written agenda and that it clearly states the purpose of the meeting, specific topics, and desired outcomes for the session.
- Begin the meeting by reviewing purpose, topics, desired outcomes, etc. Until the group is functioning well, it may be necessary to review meeting ground rules.
- Facilitate the involvement of all members, and do so in ways that encourage them to focus specifically on the task. The facilitator remains neutral in discussion of issues.
- Try to maintain a comfortable pace (neither too rushed, nor too slow; try to start on time and end on time -- but don't be a slave to the clock).
- Periodically review what has been accomplished and move on to the next item.
- Leave time to sum up and celebrate accomplishment of outcomes and end by enumerating specific follow-up activity (what, who, when). End with a plan for the next meeting (date, time, tentative agenda). For a series of meetings, set the dates well in advance so members can plan their calendars.

(cont.)

Some Group Dynamics

Despite the best of intentions, group members sometimes find it difficult to stay on task. Some of the reasons are

Hidden Agendas -- A person may feel compelled to make some point that is not on the agenda. At any meeting, there may be a number of these hidden agenda items. There is no good way to deal with these. It is important that all members understand that hidden agendas are a problem, and there should be agreement that each member will take responsibility for keeping such items in check. However, there will be times when there is little choice other than to facilitate the rapid presentation of a point and indicate where the concern needs to be redirected.

A Need for Validation -- Even when a person is task-focused, s/he may seem to be making the same point over and over. This usually is an indication that s/he feels s/he is making an important point but no one seems to be accounting for it. To counter such disruptive repetition and related problems, it is helpful to use flipcharts or a writing board on which group member points are highlighted (hopefully with some form of organization to enhance coherence and facilitate summarizing). Accounting for what is said in this visible way helps members feel their contributions have been heard and validated. It also allows the facilitator to point to a matter as a visible reminder to a member that it has already been raised. When a matter is one that warrants discussion at a later time, it can be assigned to an "agenda bin" to be addressed at a subsequent meeting.

Members are at an Impasse -- Two major reasons groups get stuck are: (a) some new ideas are needed to "get out of a box" and (b) differences in perspective need to be aired and resolved. The former problem usually can be dealt with through brainstorming or by bringing in someone who has some new alternatives to offer. The latter problem involves conflicts that arise over process, content, and power relationships and is dealt with through problem solving and conflict management strategies (e.g., accommodation, negotiation, mediation).

Interpersonal Conflict -- Some people find it hard to like each other. Sometimes the dislike is so strong that they simply can't work closely together. If there is no mechanism to help them minimize their interpersonal conflict, the group needs to find a way to restructure its membership.

Two References

Rees, F. (1993). *25 Activities for Teams.* San Diego CA: Pfeiffer & Co.

Brilhart, J.K. & Galanes, G.J. (1995). *Effective Group Discussion* (8th ed.). Madison, WI: WCB Brown & Benchmark.

A Team to Manage Care

When a client is involved with more than one intervener, management of care becomes a concern. This clearly is always the situation when a student is referred for help over and above that which her/his teacher(s) can provide.

Subsequent monitoring as part of the ongoing management of client care focuses on coordinating interventions, improving quality of care (including revising intervention plans as appropriate), and enhancing cost-efficacy.

Management of care involves a variety of activity all of which is designed to ensure that client interests are well-served. At the core of the process is enhanced monitoring of care with a specific focus on the appropriateness of the chosen interventions, adequacy of client involvement, appropriateness of intervention planning and implementation, and progress.

Such ongoing monitoring requires systems for

- tracking client involvement in interventions
- amassing and analyzing data on intervention planning and implementation
- amassing and analyzing progress data
- recommending changes

Effective monitoring depends on information systems that enable those involved with clients to regularly gather, store, and retrieve data. Schools rely heavily on forms for gathering necessary information*. In coming years, more and more of this information will be entered into computers to facilitate retrieval and assist in other ways with client care.

* Examples of such forms and related resources are provided in the accompanying aid packet on *School-Based Client Consultation, Referral, and Management of Care* -- prepared by the Center for Mental Health in Schools at UCLA..

Management of care, of course, involves more than monitoring processes and outcomes. Management also calls for the ability to produce changes as necessary.

> Sometimes steps must be taken to improve the quality of processes, including at times enhancing coordination among several interveners. Sometimes intervention plans need to be revised to increase their efficacy and minimize their "costs" -- including addressing negative "side effects." Thus, management of care involves using the findings from ongoing monitoring to clarify if interventions need to be altered and then implements strategies to identify appropriate changes and ensure they are implemented with continued monitoring. Along the way, those involved in managing the client's care may have to advocate for and broker essential help and provide the linkage among services that ensures they are coordinated. They also must enhance coordinated intervener communication with the student's caregivers at home.

Who does all this monitoring and management of care? Ideally, all involved parties -- interveners and clients -- assume these functions and become the *management team.* One member of such a team needs to take *primary* responsibility for management of care (a *primary manager*). Sites with sufficient resources often opt to employ one staff member to fill this role for all clients. However, given the limited resources available to schools, a more practical model is to train many staff to share such a role. Ultimately, with proper instruction, one or more family members might be able to assume this role.

> All who become primary managers of care must approach the role in a way that respects the client and conveys a sense of caring. The process should be oriented to problem-solving but should not be limited to problem treatments (e.g., in working on their problems, young people should not be cut off from developmental and enrichment opportunities). In most instances, a youngster's family will be integrally involved and empowered as partners, as well as recipients of care. Well-implemented management of care can help ensure that clients are helped in a comprehensive, integrated manner that addresses her/him as a whole person. A positive side effect of all this can be enhancement of systems of care.

Management teams should meet whenever analysis of monitoring information suggests a need for program changes and at designated review periods. Between meetings, it is the responsibility of the primary manager to ensure that care is appropriately monitored, team meetings are called as changes are needed, and that changes are implemented. It is the team as a whole, however, that has responsibility for designating necessary changes and working to ensure the changes are made.

A few basic tasks for primary managers of care are

- write up analyses of monitoring findings and recommendations to share with management team
- immediately after a team meeting, write up and circulate changes proposed by management team and emphasize who has agreed to do which tasks by when
- set-up a "tickler" system to remind you when to check on whether tasks have been accomplished
- follow-up with team members who have not accomplished agreed upon tasks to see what assistance they need.

STOP. THINK DISCUSS

When there are many students receiving various types of assistance, it is imperative that a school have an effective system in place to manage care.

What is the nature of the system at you school?

Who is responsible for being certain that it is working well?

Who shares the load as primary managers of care?

A Team to Manage Resources

As discussed in another unit, most school health and human service programs (as well as compensatory and special education programs) are developed and function in relative isolation of each other. Available evidence suggests this produces fragmentation which, in turn, results in waste and limited efficacy. National, state, and local initiatives aimed at increasing coordination and integration of community services are just beginning to direct school policy makers to a closer look at school-owned services. At the same time, school practitioners are realizing that since they can't work any harder, they must work smarter. For some, working smarter translates into new strategies for coordinating, integrating, and redeploying resources. Such efforts are reflected in new (a) processes for mapping and matching resources and needs and (b) mechanisms for resource coordination and enhancement. (Space precludes discussing the topic here, but all efforts to work smarter obviously can be enhanced through appropriate use of advanced technology.)

Mapping and matching resources and needs. The literature on resource coordination makes it clear that a first step in countering fragmentation involves "mapping" resources by identifying what exists at a site (e.g., enumerating programs and services that are in place to support students, families, and staff; outlining referral and case management procedures). A comprehensive form of "needs assessment" is generated as resource mapping is paired with surveys of the unmet needs of students, their families, and school staff.

Based on analyses of what is available, effective, and needed, strategies can be formulated for resource enhancement. These focus on (a) outreach to link with additional resources at other schools, district sites, and in the community and (b) better ways to use existing resources. (The process of outreach to community agencies is made easier where there is policy and organization supporting school-community collaboration. However, actual establishment of formal connections remains complex and is becoming more difficult as publicly-funded community resources dwindle.)

Perhaps the most valuable aspect of mapping and analyzing resources is that the products provide a sound basis for improving cost-effectiveness. In schools and community agencies, there is acknowledged redundancy stemming from ill-conceived policies and lack of coordination. These facts do not translate into evidence that there are pools of unneeded personnel; they simply suggest there are resources that can be used in different ways to address unmet needs. Given that additional funding for reform is hard to come by, such redeployment of resources is the primary answer to the ubiquitous question: *Where will we find the funds?*

An example of a mechanism designed to reduce fragmentation and enhance resource availability and use (with a view to enhancing cost-efficacy) is seen in the concept of a *resource coordinating team*. Creation of such a school-based team provides a good mechanism for starting to weave together existing school and community resources and encourage services and programs to function in an increasingly cohesive way.

> *A resource coordinating team differs from teams created to review individual students* (such as a student study team or a teacher assistance team). That is, its focus is not on specific cases, but on clarifying resources and their best use. In doing so, it provides what often is a missing mechanism for managing and enhancing *systems* to coordinate, integrate, and strengthen interventions. For example, this mechanism can be used to weave together the eight components of school health programs to better address such problems as on-campus violence, substance abuse, depression, and eating disorders. Such a team can be assigned responsibility for (a) mapping and analyzing activity and resources with a view to improving coordination, (b) ensuring there are effective systems for referral, case management, and quality assurance, (c) guaranteeing appropriate procedures for effective management of programs and information and for communication among school staff and with the home, and (d) exploring ways to redeploy and enhance resources -- such as clarifying which activities are nonproductive and suggesting better uses for the resources, as well as reaching out to connect with additional resources in the school district and community.

Although a resource coordinating team might be created solely around psychosocial programs, such a mechanism is meant to bring together representatives of all major programs and services supporting a school's instructional component (e.g., guidance counselors, school psychologists, nurses, social workers, attendance and dropout counselors, health educators, special education staff, bilingual program coordinators). This includes representatives of any community agency that is significantly involved at the school. It also includes the energies and expertise of one of the site's administrators, regular classroom teachers, noncertificated staff, parents, and older students. Where creation of "another team" is seen as a burden, existing teams can be asked to broaden their scope. Teams that already have a core of relevant expertise, such as student study teams, teacher assistance teams, and school crisis teams, have demonstrated the ability to extend their focus to resource coordination.

Some General Guidelines for Establishing School-Site Collaborative Teams Focused on Addressing Barriers to Learning

Two basic problems in forming collaborative teams at school-sites are (a) identifying and deploying committed and able personnel and (b) establishing an organizational structure that provides sufficient time and nurtures the competence and commitment of team members. The following are some suggestions that can help in dealing with these problems.

1. For staff, job descriptions and evaluations must reflect a policy that personnel are expected to work in a coordinated and increasingly integrated way with the aim of maximizing resource use and enhancing effectiveness.

2. To maximize resource coordination and enhancement at a school, every staff member must be encouraged to participate on some team designed to improve students' classroom functioning. The importance of such teams should be recognized through provision of time and resources that allow team members to build capacity and work effectively together.

3. Teams may consist of current resource staff, special project staff, teachers, site administrators, parents, older students, and others from the community. In this last regard, representatives of school-linked community services must be included. Individuals should be encouraged to choose a team whose work interests them.

4. Group should vary in size -- from two to as many as are needed and interested. Major criteria used in determining size should be factors associated with efficient and effective functioning. The larger the group, the harder it is to find a meeting time and the longer each meeting tends to run. Frequency of meetings depends on the group's functions, time availability, and ambitions. Properly designed and trained teams can accomplish a great deal through informal communication and short meetings.

5. The core of a team is staff who have or will acquire the ability to carry out identified functions and make the mechanism work; others can be auxiliary members. All should be committed to the team's mission. Building team commitment and competence should be one major focus of school management policies and programs.

6. Because several teams require the expertise of the same staff (nurse, psychologist, counselor, resource teacher, social worker), these individuals will necessarily be on more than one team.

7. Each team needs a dedicated leader/facilitator who has the ability to keep the group task-focused and productive and someone who records decisions and plans and reminds members of planned activity and products.

8. Team functioning is enhanced through use of computer technology (management systems, electronic bulletin boards and mail, resource clearinghouses). Such technology facilitates communication, networking, program planning and implementation, linking activity, and a variety of budgeting, scheduling, and other management concerns.

9. Effective teams should be able to produce savings in terms of time and resources through appropriately addressing their areas of focus. In addition, by tapping into public health-care funds, a district may be able to underwrite some of the costs of those team members who also provide specific services.

Properly constituted, trained, and supported, a resource coordinating team can complement the work of the site's governance body through providing on-site overview, leadership, and advocacy for all activity aimed at addressing barriers to learning and enhancing healthy development. Having at least one representative from the resource coordinating team on the school's governing and planning bodies helps ensure that essential programs and services are maintained, improved, and increasingly integrated with classroom instruction.

Local Schools Working Together

To facilitate resource coordination and enhancement among a complex of schools (e.g., a high school and its feeder middle and elementary schools), a resource coordinating *council* can be established by bringing together representatives of each school's resource coordinating *team*. Such a complex of schools needs to work together because in many cases they are concerned with the same families (e.g., a family often has children at each level of schooling). Moreover, schools in a given locale try to establish linkages with the same community resources. A coordinating council for a complex of schools provides a mechanism to help ensure cohesive and equitable deployment of such resources.

As a follow-up aid for you and your school, included in the accompanying material is an introductory packet entitled *Working Together: From School-Based Teams to School-Higher Education Connections* -- prepared by the Center for Mental Health in Schools at UCLA.

For more about Resource Coordinating Teams, see

H.S. Adelman (1993). School-linked mental health interventions: Toward mechanisms for service coordination and integration. *Journal of Community Psychology, 21,* 309-319.

L. Rosenblum, M.B. DiCecco, L. Taylor, & H.S. Adelman (1995). Upgrading school support programs through collaboration: Resource Coordinating Teams. *Social Work in Education, 17,* 117-124.

BEST COPY AVAILABLE

Test Questions -- Unit III: Section B

(1) Enumerate two of the basis tasks for primary managers of care as discussed in this unit.

_____

_____

(2) Enumerate two of the major functions of a school-based team designed to manage resources as discussed in this unit.

_____

_____

(3) Parents can be part of a management of care team.

True ____ False____

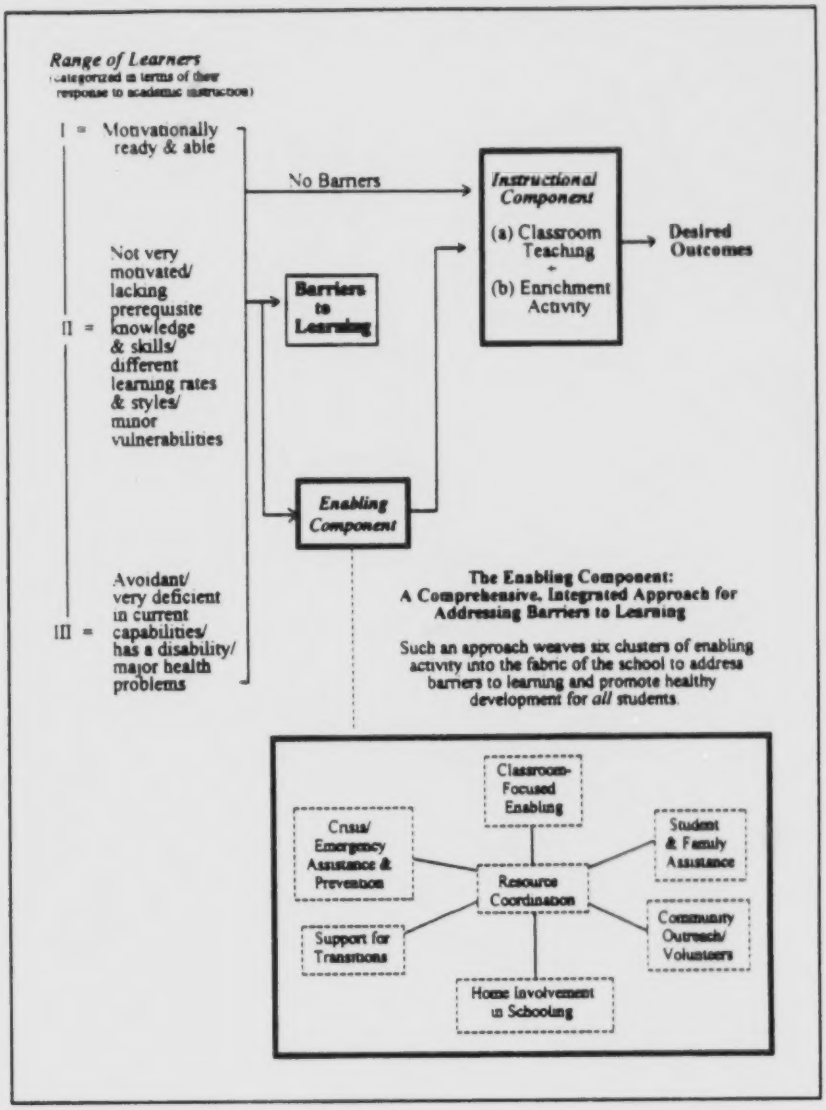
(4) Perhaps the most valuable aspect of mapping and analyzing a school's resources for addressing barriers to learning and promoting healthy development is that the products provide a sound basis for improving cost-effectiveness.

True ____ False____

(5) A school-based Resource Coordinating Team has the same functions as a team created to review individual students.

True ____ False____

Section C: Building a Comprehensive, Integrated Approach at Your School


Range of Learners
(categorized in terms of their response to academic instruction)
I = Motivationally ready & able
II = Not very motivated/ lacking prerequisite knowledge & skills/ different learning rates & styles/ minor vulnerabilities
III = Avoidant/ very deficient in current capabilities/ has a disability/ major health problems
No Barriers
Barriers to Learning
Instructional Component
(a) Classroom Teaching
+
(b) Enrichment Activity
Desired Outcomes
Enabling Component
The Enabling Component:
A Comprehensive, Integrated Approach for Addressing Barriers to Learning
Such an approach weaves six clusters of enabling activity into the fabric of the school to address barriers to learning and promote healthy development for all students.
Classroom-Focused Enabling
Crisis/ Emergency Assistance & Prevention
Student & Family Assistance
Resource Coordination
Community Outreach/ Volunteers
Support for Transitions
Home Involvement in Schooling

Contents:

Classroom-Focused Enabling
Crisis Assistance and Prevention
Support for Transitions
Student and Family Assistance
Home Involvement in Schooling
Community Outreach for Involvement and Support (including a focus on volunteers)

BEST COPY AVAILABLE

Objectives for Section C

After completing this section of the unit, your should be able to:

- identify three components that need to be addressed in school and community efforts for systemic reform
- identify six program areas of an enabling component

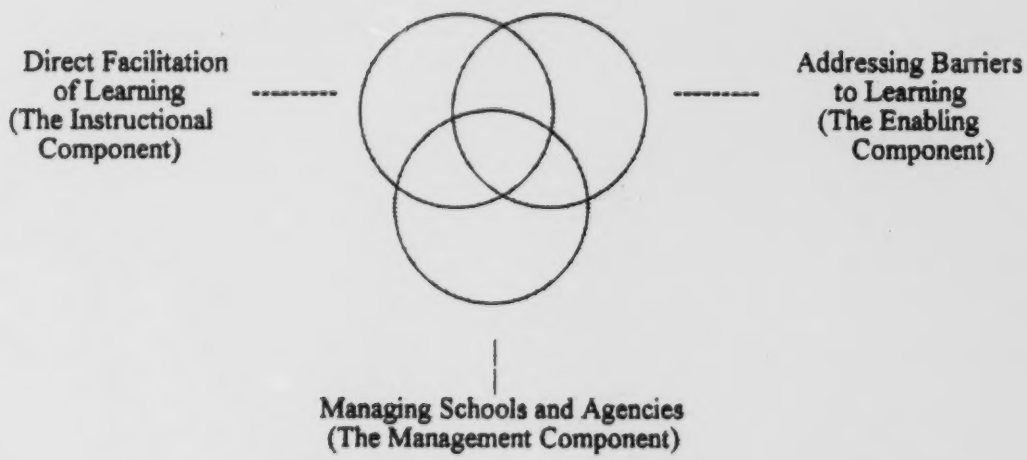
A Few Focusing Questions

- *What is an enabling component?*
- *To which of the six areas of an enabling component might you make a significant contribution?*

Even more fundamentally than establishing *linkages* between community agencies and school sites, school and community policy must start to reflect the reality that there are three primary and essential components to be addressed in systemic reform and restructuring of schools and community agencies.

As illustrated below, these are the *instructional, enabling*, and *management* components.

Three Components to be Addressed in Systemic Reform


Direct Facilitation of Learning (The Instructional Component)
Addressing Barriers to Learning (The Enabling Component)
Managing Schools and Agencies (The Management Component)

Central to an effective *enabling component* is activity to address health and psychosocial problems.

BEST COPY AVAILABLE

School-owned enabling activity -- such as pupil services and the multi-components of a school health program -- must be coordinated and integrated not only with each other but with community-owned resources.

> And the overlapping enabling, instructional, and management components must be carried out as a cohesive whole if we are to effectively address the many barriers interfering with the appropriate and effective functioning of students.

Emergence of a cohesive Enabling Component requires (1) weaving together what is available at a school, (2) expanding what exists by integrating school and community resources, and (3) enhancing access to community programs and services by linking as many as feasible to programs at school sites in ways that can serve a complex of schools.

> Based on analyses of what schools and communities already are doing, enabling activity can be clustered into six program areas. These encompass interventions to
>
> - work with teachers to enhance classroom based efforts to enable learning
> - provide prescribed student and family assistance
> - respond to and prevent crises
> - support student and family transitions
> - mobilize parent/home involvement in schooling and health promotion
> - outreach to develop greater community involvement and support (including recruitment of volunteers).

A brief skecth of each of these programmatic areas follows.

Classroom Focused Enabling

When a teacher encounters difficulty in working with a youngster, the first step is to see whether there are ways to address the problem within the regular classroom and perhaps with added home involvement. Thus the emphasis here is on enhancing classroom-based efforts to enable learning by increasing teacher effectiveness for preventing and handling problems in the classroom. This is accomplished by providing personalized help to increase a teacher's array of strategies for working with a wider range of individual differences. For example, teachers learn to use peer tutoring and volunteers to enhance social and academic support and to increase their range of accommodative strategies and their ability to teach students compensatory strategies; and as appropriate, they are provided support in the classroom from resource and itinerant teachers and counselors. Two aims of all this are to increase mainstreaming efficacy and reduce the need for special services.

Work in this area requires

- programs for personalized professional development (for teachers and aides)
- systems to expand resources
- programs for temporary out of class help
- programs to develop aides, volunteers, and any others who help in classrooms or who work with teachers to enable learning.

Through classroom-focused enabling programs, teachers are better prepared to address similar problems when they arise in the future.

(The classroom curriculum, of course, already should encompass a focus on fostering socio-emotional and physical development. Such a focus is seen as an essential element in preventing learning, behavior, emotional, and health problems.)

Student and Family Assistance

Some problems cannot be handled without special interventions, thus the need for student and family assistance. The emphasis here is on providing special services in a personalized way to assist with a broad-range of needs. To begin with, available social, physical and mental health programs in the school and community are used. As community outreach brings in other resources, they are linked to existing activity in an integrated manner. Special attention is paid to enhancing systems for triage, case and resource management, direct services to meet immediate needs, and referral for special services and special education resources and placements as appropriate. Ongoing efforts are made to expand and enhance resources. As major outcomes, the intent is to ensure special assistance is provided when necessary and appropriate and that such assistance is effective.

Work in this area requires

- programs designed to support classroom focused enabling -- with specific emphasis on reducing the need for teachers to seek special programs and services
- a stakeholder information program to clarify available assistance and how to access help
- systems to facilitate requests for assistance and strategies to evaluate the requests (including use of strategies designed to reduce the need for special intervention)
- a programmatic approach for handling referrals
- programs providing direct service
- programmatic approaches for effective case and resource management
- interface with community outreach to assimilate additional resources into current service delivery.

Crisis Assistance and Prevention

The intent here is to respond to, minimize the impact of, and prevent crises. Desired outcomes of crisis assistance include ensuring immediate emergency and follow-up care is provided so students are able to resume learning without undue delay. Prevention activity outcomes are reflected in measures showing there is a safe and productive environment and that students and their families have the type of attitudes and capacities needed to deal with violence and other threats to safety.

Work in this area requires

- systems and programs for emergency/crisis response at a site, throughout a school complex, and community-wide (including a program to ensure follow-up care)
- prevention programs for school and community to address school safety and violence reduction, suicide prevention, child abuse prevention and so forth.

Support for Transitions

This area involves planning, developing, and maintaining a comprehensive focus on the variety of transitions concerns confronting students and their families. Anticipated outcomes are reduced alienation and increased positive attitudes toward and involvement in school and learning activities.

Work in this area requires

- programs creating a welcoming and socially supportive school community, especially for new arrivals
- counseling and articulation programs to support grade-to-grade and school-to-school transitions, moving to and from special education, going to college, moving to post school living and work
- before, after-school, and intersession programs to enrich learning and provide safe recreation.

Home Involvement in Schooling

The emphasis and work in this area includes

- programs to address specific learning and support needs of adults in the home, such as English as a Second Language (ESL) classes and mutual support groups
- programs to help those in the home meet their basic obligations to the student, such as instruction for parenting and for helping with schoolwork
- systems to improve communication about matters essential to the student and family
- programs to enhance the home-school connection and sense of community
- interventions to enhance participation in making decisions that are essential to the student
- programs to enhance home support related to the student's basic learning and development
- interventions to mobilize those at home to problem solve related to student needs
- intervention to elicit help (support, collaborations, and partnerships) from those at home with respect to meeting classroom, school, and community needs.

The context for some of this activity may be a *parent center* (which may be part of a *Family Service Center* facility if one has been established at the site).

Outcomes include measures of parent learning, student progress, and community enhancement specifically related to home involvement.

Community Outreach for Involvement and Support
(including a focus on volunteers)

Outreach to the community is used to build linkages and collaborations, develop greater involvement in schooling, and enhance support for efforts to enable learning. Outreach is made to (1) public and private community agencies, universities, colleges, organizations, and facilities, (2) businesses and professional organizations and groups, and (3) volunteer service programs, organizations, and clubs. Outcomes include measures of community participation, student progress, and community enhancement.

Work in this area requires

- programs to recruit community involvement and support (e.g., linkages and integration with community health and social services; cadres of volunteers, mentors, and individuals with special expertise and resources; local businesses to adopt-a-school and provide resources, awards, incentives, and jobs; formal partnership arrangements)

- systems and programs specifically designed to train, screen, and maintain volunteers (e.g., parents, college students, senior citizens, peer and cross-age tutors and counselors, and professionals-in-training to provide direct help for staff and students -- especially targeted students)

- programs outreaching to hard to involve students and families (those who don't come to school regularly -- including truants and dropouts)

- programs to enhance community-school connections and sense of community (e.g., orientations, open houses, performances and cultural and sports events, festivals and celebrations, workshops and fairs).

STOP. THINK. DISCUSS

Every school has programs and services that are meant to address barriers to student learning and enhance healthy development.

Make a list of the ones that are currently in place at your school.

If you were to ask most of the teachers at the school, would they know that these interventions are available and understand how to arrange for students to access them?

What other programs and services do you think the school needs to better address mental health and psychosocial problems?

In organizing an enabling component, it is the content of each of the basic areas that guides program planning, implementation, evaluation, personnel development, and stakeholder involvement.

The intent is to blend a *continuum of programs* -- from primary prevention to treatment of chronic problems -- and a *continuum of interveners, advocates*, and *sources of support* (e.g., peers, parents, volunteers, nonprofessional staff, professionals-in-training, professionals).

Thus, the emphasis throughout is on *collaboration* -- cooperation, coordination, and, where viable, integration -- among all enabling activities, as well as with the instructional and management components.

If feasible, a *Center* facility provides a useful focal point and hub for enabling component operations.

Also as feasible, integrated use of advanced *technology* is highly desirable (e.g., a computerized system to organize information, aid case management, and link students and families to referrals).

It is clear that there is a long way to go before, a comprehensive, integrated approach to addressing barriers to learning and promoting healthy development is in place. Nevertheless, as we move into the next millennium, it seems wise to work within a context that has promise for truly meeting the needs of society rather than continuing to pursue fragmented strategies that have proven ineffective.

For more on this topic, see

H.S. Adelman (1996). *Restructuring Education Support Services: Toward the Concept of an Enabling Component.* Kent, OH: American School Health Association.

H.S. Adelman & L. Taylor (in press) System reform to address barriers to learning: Beyond school-linked services and full service schools. *American Journal of Orthopsychiatry.*

The Center also has several guidebooks related to developing an Enabling Component and restructuring education support programs at school sites and in school districts.

BEST COPY AVAILABLE

Test Questions -- Unit III: Section C

(1) Indicate three primary and essential components discussed in this unit that need to be addressed in reform efforts by schools/communities.

_____

_____

_____

(2) Enumerate six program areas of an Enabling Component.

_____

_____

_____

_____

_____

_____

(3) The concepts of (a) an Enabling Component and (b) School linked services are different terms for the same approach to addressing barriers to learning and enhancing healthy development.

True ____ False____

(4) School-owned enabling activity -- such as pupil services and the multi-components of a school health program -- must be coordinated and integrated not only with each other but with community-owned resources.

True ____ False____

Coda: New Roles for Schools: A Multifaceted Focus

Obviously, schools have always played a key role in promoting health and helping students. Now, school professionals have the opportunity and the responsibility to play an expanded and essential role in moving schools toward a comprehensive, integrated approach for dealing with barriers to learning, and in the process, they can enhance efforts to promote healthy development.

> Emerging reforms are reshaping the work of all school professionals. Pupil services in schools are expanding and changing rapidly. Pupil services professionals are engaged in an increasingly wide array of activity, including promotion of health and social and emotional development, direct services, outreach to families, and various forms of support for teachers and other school personnel. There is enhanced emphasis on coordination and collaboration within a school and with community agencies to provide the "network of care" necessary to deal with complex problems over time.

New directions call for functions that go beyond direct service and traditional consultation. All who work in the schools must be prepared not only to provide direct help but to act as advocates, catalysts, brokers, and facilitators of systemic reform. Particularly needed are efforts to improve intervention efficacy through integrating physical and mental health and social services. More extensively, the need is for systemic restructuring of all support programs and services into a comprehensive and cohesive set of programs.

> It seems evident that the relatively small number of pupil service personnel available to schools can provide only a small proportion of the direct services needed by students. The more their expertise is used at the level of program organization, development, and maintenance, the greater the number students who will benefit.

This leads to the view that the range of functions pupil service specialists should perform for schools are

- Direct service activity (e.g., crisis intervention in emergency situations; short-term assessment and treatment, including facilitating referral and case management; prevention through promotion of physical and mental health and enhancing resources through supervising professionals-in-training and volunteers),
- Resource coordination and development (e.g., organizing existing programs; integrating with instruction through inservice mentoring and consultation; interfacing with community agencies to create formal linkages; preparing proposals and developing new programs; acting as an agent of change to create readiness for systemic reform and facilitating development of mechanisms for collaboration and integration; providing support for maintenance of reforms; participation on school governance and planning bodies),
- Enhancing access to community resources (e.g., identifying community resources; assisting families to connect with services; working with community resources to be more responsive to the needs of a district's students; community coalition building).

Furthermore, these three areas of function should be prioritized so school-based professionals can use their time to produce the broadest impact.

Used properly, pupil service personnel can play a potent role in creating a comprehensive, integrated approach to meeting the needs of the young by interweaving what schools can do with what the community offers.

Overcoming today's limitations and meeting tomorrow's challenges requires a clear picture of where we want to go and how we can get there. Over the next few years, there will be fundamental changes in the ways in which the needs of young people are addressed. We all have the opportunity to play key roles in redesigning schools internally and in terms of how they work with others in the surrounding community to better address barriers to learning and enhance healthy development. Our hope is that the material presented in this set of continuing education units has provided you not only with some new skills, but with a picture of emerging trends and their implications for new roles and new directions.

GLOSSARY OF KEY TERMS, ACRONYMS, AND LAWS

Those interested in psychosocial and mental health concerns encounter a host of specialized terms, acronyms, and references to legislation. On the following pages, you will find a brief resource aid and references to the sources from which they were drawn should you want to pursue more extensive glossaries.

Included here are:

Excerpts from:

American Psychiatric Glossary (seventh edition; 1994) published by the American Psychiatric Press (Washington, DC)

a glossary of acronyms and laws related to emotional and behavior disorders compiled by the Institute for Adolescents with Behavioral Disorders, Arden Hills, MN

Also included is a copy of

Children's and Adolescents' Mental Health: A Glossary of Terms prepared and circulated by the U.S. Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services

Some Key Terms Related to Mental Health and Psychosocial Problems

The following is a sampling of key terms from the American Psychiatric Glossary (7th edition, edited by Jane Edgerton and Robert Campbell, III [1994]. Washington, DC: American Psychiatric Press, Inc.). It provides a user-friendly definition for quick referral. For a more extensive listing of terms, see the original source.

abnormality In psychological terms, any mental, emotional, or behavioral activity that deviates from culturally or scientifically accepted norms.

abreaction Emotional release or discharge after recalling a painful experience that has been repressed because it was not consciously tolerable (see *conscious).* A therapeutic effect sometimes occurs through partial or repeated discharge of the painful *affect.* See also *systematic desensitization.*

academic disorders In DSM-IV, this is a major group of *infancy, childhood, and adolescence disorders* that includes *reading disorder, mathematics disorder,* and disorder of *written expression.*

acculturation difficulty A problem in adapting to or finding an appropriate way to adapt to a different culture or environment. The problem is not based on any coexisting *mental disorder.*

acting out Expressions of *unconscious* emotional conflicts or feelings in actions rather than words. The person is not consciously aware of the meaning of such acts (see *conscious).* Acting out may be harmful or, in controlled situations, therapeutic (e.g., children's play therapy).

adaptation Fitting one's behavior to meet the needs of one's environment, which often involves a modification of impulses, emotions, or attitudes.

adjustment Often transitory functional alteration or accommodation by which one can better adapt oneself to the immediate environment and to one's inner self. See also *adaptation.*

adjustment disorder An imprecise term referring to emotional or behavioral *symptoms* that develop in response to an identifiable stressor. The symptoms, which may include *anxiety,* depressed mood, and disturbance of conduct, are clinically significant in that the distress exceeds what would be expected under the circumstances, or significant impairment in social or occupational functioning is produced. Duration of symptoms tends to be self-limited, not persisting more than 6 months after termination of the stressor or its consequences. Sometimes the disorder is designated as "acute" if duration is 6 months or less, and as "persistent" or "chronic" if symptoms endure beyond 6 months.

affect Behavior that expresses a subjectively experienced feeling state *(emotion);* affect is responsive to changing emotional states, whereas mood refers to a pervasive and sustained emotion. Common affects are euphoria, anger, and sadness. Some types of affect disturbance are:

blunted Severe reduction in the intensity of affective expression.

flat Absence or near absence of any signs of affective expression such as a monotonous voice and an immobile face.

inappropriate Discordance of voice and movements with the content of the person's speech or ideation.

labile Abnormal variability, with repeated, rapid, and abrupt shifts in affective expression.

restricted or constricted Reduction in the expressive range and intensity of affects.

affective disorder A disorder in which mood change or disturbance is the primary manifestation. Now referred to as *mood disorder.* See *depression.*

aggression Forceful physical, verbal, or symbolic action. May be appropriate and self-protective, including healthy self-assertiveness, or inappropriate as in hostile or destructive behavior. May also be directed toward the environment, toward another person or *personality*, or toward the self, as *in depression*.

agitation Excessive motor activity, usually nonpurposeful and associated with internal tension. Examples include inability to sit still, fidgeting, pacing, wringing of hands, and pulling of clothes. See *psychomotor agitation*.

agoraphobia *Anxiety* about being in places or situations in which escape might be difficult or embarrassing or in which help may not be available should a *panic attack* occur. The fears typically relate to venturing into the open, of leaving the familiar setting of one's home, or of being in a crowd, standing in line, or traveling in a car or train. Although agoraphobia usually occurs as a part of *panic disorder*, agoraphobia without a history of panic disorder has been described.

Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) An agency in the U.S. Department of Health and Human Services that was replaced in 1992 by the Substance Abuse and Mental Health Services Administration (SAMHSA). In reorganizing ADAMHA into SAMHSA, the three ADAMHA research institutes, the National Institute on Alcohol Abuse and Alcoholism (NIAAA), the National institute on Drug Abuse (NIDA), and the National Institute of Mental Health (NIMH), were moved to the *National Institutes of Health*. What remain in SAMHSA are the substance abuse and mental health services programs.

alcohol use disorders In DSM-IV, this group includes alcohol dependence, alcohol abuse, alcohol intoxication, alcohol withdrawal, alcohol delirium, alcohol persisting dementia, alcohol persisting amnestic disorder, alcohol psychotic disorder, alcohol mood disorder, alcohol anxiety disorder, alcohol sleep disorder, and alcohol sexual dysfunction. See *abuse, substance; dependence, substance; intoxication, alcohol; withdrawal symptoms, alcohol*.

ambivalence The coexistence of contradictory emotions, attitudes, ideas, or desires with respect to a particular person, object, or situation. Ordinarily, the ambivalence is not fully *conscious* and suggests psychopathology only when present in an extreme form.

amphetamine use disorders In DSM-IV, this group includes amphetamine (or related substance) dependence, amphetamine abuse, amphetamine intoxication, amphetamine withdrawal, amphetamine delirium, amphetamine psychotic disorder, amphetamine mood disorder, amphetamine anxiety disorder, amphetamine sexual dysfunction, and amphetamine sleep disorder.

androgyny A combination of male and female characteristics in one person.

anhedonia Inability to experience pleasure from activities that usually produce pleasurable feelings. Contrast with *hedonism*.

anniversary reaction An emotional response to a previous event occurring at the same time of year. Often the event involved a loss and the reaction involves a *depressed* state. The reaction can range from mild to severe and may occur at any time after the event.

anomie Apathy, alienation, and personal distress resulting from the loss of goals previously valued. Emile Durkheim popularized this term when he listed it as a principal reason for *suicide*.

anorexia nervosa An *eating disorder* characterized by refusal or inability to maintain minimum normal weight for age and height combined with intense fear of gaining weight, denial of the seriousness of current low weight, undue influence of body weight or shape on self-evaluation, and, in females, amenorrhea or failure to menstruate. Weight is typically 15% or more below normal, and it may decrease to life-threatening extremes. In the restricting subtype, the person does not engage regularly in binge eating. In the binge eating/purging, or bulimic, subtype, the person engages in recurrent episodes of *binge eating* or purging during the episode of anorexia nervosa. See also *bulimia nervosa*.

Antabuse (disulfiram) A drug used in treatment of *alcohol dependence to* create an aversive response to alcohol. It blocks the normal metabolism of alcohol and produces increased blood concentrations of acetaldehyde that induce distressing *symptoms* such as flushing of the skin, pounding of the heart, shortness of breath, nausea, and vomiting. With more severe reactions, hypertension, cardiovascular collapse, and, sometimes, convulsions may occur.

antisocial behavior Conduct indicating indifference to another's person or property; criminal behavior, dishonesty, or abuse are examples. In DSM-IV, childhood or adolescent antisocial behavior and adult antisocial behavior (in contrast to antisocial personality disorder, etc.) are included as "other conditions that may be a focus of clinical attention."

anxiety Apprehension, tension, or uneasiness from anticipation of danger, the source of which is largely unknown or unrecognized. Primarily of *intrapsychic* origin, in distinction to *fear*, which is the emotional response to a consciously recognized and usually external threat or danger. May be regarded as pathologic when it interferes with effectiveness in living, achievement of desired goals or satisfaction, or reasonable emotional comfort.

anxiety disorders In DSM-IV, this category includes panic disorder without agoraphobia, panic disorder with agoraphobia, agoraphobia without history of panic disorder, specific (simple) phobia, social phobia (social anxiety disorder), obsessive-compulsive disorder, posttraumatic stress disorder, acute stress disorder, generalized anxiety disorder (includes overanxious disorder of childhood), anxiety disorder due to a general medical condition, and substance-induced anxiety disorder. (The inclusion of mixed anxiety-depressive disorder into this category awaits further study.) See *agoraphobia; generalized anxiety disorder; mixed anxiety-depressive disorder; obsessive-compulsive disorder; panic disorder; phobia; posttraumatic stress disorder.*

Asperger's disorder A disorder of development characterized by gross and sustained impairment in social interaction and restricted, repetitive, and stereotyped patterns of behavior, interests, and activities occurring in the context of preserved cognitive and language development.

attachment disorder, reactive A disorder of infancy or early childhood, beginning before the child is 5 years old, characterized by markedly disturbed and developmentally inappropriate social relatedness. In the inhibited type of reactive attachment disorder, failure to respond predominates, and responses are hypervigilant, avoidant, or highly ambivalent and contradictory. *Frozen watchfulness* maybe present. In the disinhibited type, indiscriminate sociability is characteristic, such as excessive familiarity with relative strangers or lack of selectivity in choice of attachment figures. The majority of children who develop this disorder (either type) are from a setting in which care has been grossly pathogenic. Either the caregivers have continually disregarded the child's basic physical and emotional needs, or repeated changes of the primary caregiver have prevented the formation of stable attachments.

attention-deficit/hyperactivity disorder (ADHD) A child whose inattention and hyperactivity-impulsivity cause problems may have this disorder. *Symptoms* appear before the age of 7 years and are inconsistent with the subject's developmental level and severe enough to impair social or academic functioning.

In the predominantly inattentive type, characteristic symptoms include distractibility, difficulty in sustaining attention or following through on instructions in the absence of close supervision, avoidance of tasks that require sustained mental effort, failure to pay close attention to details in schoolwork or other activities, difficulty in organizing activities, not listening to what is being said to him or her, loss of things that are necessary for assignments, and forgetfulness in daily activities.

In the predominantly hyperactive-impulsive type, characteristic symptoms are that the person inappropriately leaves his or her seat in classroom or runs about, fidgets or squirms, has difficulty in engaging in leisure activities quietly, has difficulty in awaiting turn in games, and blurts out answers to questions before they are completed. The two types may be combined.

autistic disorder A disorder of development consisting of gross and sustained impairment in social interaction and communication; restricted and stereotyped patterns of behavior, interest, and activities; and abnormal development prior to age 3 manifested by delays or abnormal functioning in social development, language communication, or play. Specific *symptoms* may include impaired awareness of others, lack of social or emotional reciprocity, failure to develop peer relationships appropriate to developmental level, delay or absence of spoken language and abnormal nonverbal communication, stereotyped and repetitive language, idiosyncratic language, impaired imaginative play, insistence on sameness (e.g., nonfunctional routines or rituals), and stereotyped and repetitive motor mannerisms.

aversion therapy A *behavior therapy* procedure in which associated with undesirable behavior are paired with a painful or unpleasant stimulus, resulting in the suppression of the undesirable behavior.

biofeedback The use of instrumentation to provide information (i.e. feedback) about variations in one or more of the subject's own physiological processes not ordinarily perceived (e.g., brain wave activity, muscle tension, blood pressure). Such feedback over a period of time can help the subject learn to control certain physiological processes even though he or she is unable to articulate how the learning was achieved.

bipolar disorders In DSM-IV, a group of *mood disorders* that includes bipolar disorder, single episode; bipolar disorder, recurrent; and *cyclothymic disorder*.

A bipolar disorder includes a manic episode at some time during its course. In any particular patient, the bipolar disorder may take the form of a single manic episode (rare), or it may consist of recurrent episodes that are either manic or depressive in nature (but at least one must have been predominantly manic).

bisexuality Originally a concept of *Freud*, indicating a belief that components of both sexes could be found in each person. Today the term is often used to refer to persons who are capable of achieving orgasm with a partner of either sex. See also *gender role*; *homosexuality*.

blocking A sudden obstruction or interruption in spontaneous flow of thinking or speaking, perceived as an absence or deprivation of thought.

bonding The unity of two people whose identities are significantly affected by their mutual interactions. Bonding often refers to the an attachment between a mother and her child.

brief psychotherapy Any form of *psycbotberapy* whose end point is defined either in terms of the number of sessions (generally not more than 15) or in terms of specified objectives; usually goal-oriented, circumscribed, active, focused, and directed toward a specific problem or *symptom*.

bulimia nervosa An *eating disorder* characterized by recurrent episodes of *binge eating* followed by compensatory behavior such as purging (i.e., self-induced vomiting or the use of diuretics and laxatives) or other methods to control weight (e.g., strict dieting, fasting, or vigorous exercise).

burnout A stress reaction developing in persons working in an area of unrelenting occupational demands. *Symptoms* include impaired work performance, fatigue, *insomnia*, *depression*, increased susceptibility to physical illness, and reliance on alcohol or other drugs of abuse for temporary relief.

catatonia Immobility with muscular rigidity or inflexibility and at times excitability. See also *schizophrenia*.

catharsis The healthful (therapeutic) release of ideas through "talking out" *conscious* material accompanied by an appropriate emotional reaction. Also, the release into awareness of repressed ("forgotten") material from the *unconscious*. See also *repression*.

character disorder (character neurosis) A *personality disorder* manifested by a chronic, habitual, maladaptive pattern of reaction that is relatively inflexible, limits the optimal use of potentialities, and often provokes the responses from the environment that the person wants to avoid. In contrast to symptoms of *neurosis*, character traits are typically *ego-syntonic*.

clanging A type of thinking in which the sound of a word, rather than its meaning, gives the direction to subsequent associations. Punning and rhyming may substitute for logic, and language may become increasingly a senseless *compulsion* to associate and decreasingly a vehicle for communication. For example, in response to the statement "That will probably remain a mystery," a patient said, "History is one of my strong points."

cluster suicides Multiple *suicides*, usually among adolescents, in a circumscribed period of time and area. Thought to have an element of contagion.

cocaine use disorders In DSM-IV, this group includes cocaine dependence, cocaine abuse, cocaine intoxication, cocaine withdrawal, cocaine delirium, cocaine psychotic disorder with delusions or hallucinations, cocaine mood disorder, cocaine anxiety disorder, cocaine sexual dysfunction, and cocaine sleep disorder.

codependency A popular term referring to all the effects that people who are dependent on alcohol or other substances have on those around them, including the attempts of those people to affect the dependent person. The term implies that codependence is a psychiatric disorder and hypothesizes that the family's actions tend to perpetuate (enable) the person's dependence. Empirical studies, however, support a stress and coping model for explanation of the family behavior.

cognitive Refers to the mental process of comprehension, judgment, memory, and reasoning, in contrast to emotional and volitional processes. Contrast with conative.

cognitive-behavioral psychotherapy Cognitive therapy; a short-term psychotherapy directed at specific target conditions or *symptoms. (Depression* has been the most intensively investigated to date.) The symptoms themselves are clues to the patient's verbal thoughts, images, and assumptions that account for both the symptomatic state and the psychological vulnerability to that state. Initial treatment is aimed at symptom reduction. The patient is taught to recognize the negative cognitions that contribute significantly to the development or maintenance of symptoms and to evaluate and modify such thinking patterns. The second phase of treatment concerns the underlying problem.

comorbidity The simultaneous appearance of two or more illnesses, such as the co-occurrence of *schizophrenia* and substance abuse or of *alcohol dependence and depression.* The association may reflect a causal relationship between one disorder and another or an underlying vulnerability to both disorders. Also, the appearance of the illnesses may be unrelated to any common etiology or vulnerability.

compensation A *defense mechanism,* operating unconsciously (see *unconscious),* by which one attempts to make up for real or fancied deficiencies. Also a *conscious* process in which one tries to make up for real or imagined defects of physique, performance skills, or psychological attributes. The two types frequently merge. See also *Adler; individual psychology; overcompensation.*

complex A group of associated ideas having a common, strong emotional tone. These ideas are largely *unconscious* and significantly influence attitudes and associations. See also *Oedipus complex.*

compulsion Repetitive ritualistic behavior such as hand washing or ordering or a mental act such as praying or repeating words silently that aims to prevent or reduce distress or prevent some dreaded event or situation. The person feels driven to perform such actions in response to an *obsession* or according to rules that must be applied rigidly, even though the behaviors are recognized to be excessive or unreasonable.

conduct disorder A *disruptive behavior disorder* of childhood characterized by repetitive and persistent violation of the rights of others or of age-appropriate social norms or rules. *Symptoms* may include bullying others, truancy or work absences, staying out at night despite parental prohibition before the age of 13, using alcohol or other substances before the age of 13, breaking into another's house or car, firesetting with the intent of causing serious damage, physical cruelty to people or animals, stealing, or use more than once of a weapon that could cause harm to others (e.g., brick, broken bottle, or gun).

conversion disorder One of the *somatoform disorders* (but in some classifications called a *dissociative disorder),* characterized by a *symptom* suggestive of a neurologic disorder that affects sensation or voluntary motor function. The symptom is not consciously or intentionally produced, it cannot be explained fully by any known *general medical condition,* and it is severe enough to impair functioning or require medical attention. Commonly seen symptoms are blindness, double vision, deafness, impaired coordination, paralysis, and seizures.

coping mechanisms Ways of adjusting to environmental stress without altering one's goals or purposes; includes both *conscious and unconscious* mechanisms.

coprophagia Eating of filth or feces.

counterphobia Deliberately seeking out and exposing oneself to, rather than avoiding, the object or situation that is consciously or unconsciously feared.

countertransference The therapist's emotional reactions to the patient that are based on the therapist's *unconscious* needs and conflicts, as distinguished from his or her *conscious* responses to the patient's behavior. Countertransference may interfere with the therapist's ability to understand the patient and may adversely affect the therapeutic technique. Currently, there is emphasis on the positive aspects of countertransference and its use as a guide to a more empathic understanding of the patient.

crack Freebase or alkaloidal *cocaine* that is named for the cracking sound it makes when heated. Also known as "rock" for its crystallized appearance. It is ingested by inhalation of vapors produced by heating the "rock."

cyclothymic disorder In DSM-IV, one of the *bipolar disorders* characterized by numerous hypomanic episodes and frequent periods of depressed mood or loss of interest or pleasure. These episodes do not meet the criteria for a full manic episode or major depressive disorder.

decompensation The deterioration of existing defenses (see *defense mechanism)*, leading to an exacerbation of pathological behavior.

defense mechanism *Unconscious* intrapsychic processes serving to provide relief from emotional *conflict and anxiety. Conscious* efforts are frequently made for the same reasons, but true defense mechanisms are unconscious. Some of the common defense mechanisms defined in this glossary are *compensation, conversion, denial, displacement, dissociation, idealization, identification, incorporation, introjection, projection, rationalization, reaction formation, regression, sublimation, substitution, symbolization, and undoing.*

delusion A false belief based on an incorrect inference about external reality and firmly sustained despite clear evidence to the contrary. The belief is not part of a cultural tradition such as an article of religious faith. Among the more frequently reported delusions are the following:

delusion of control The belief that one's feelings, impulses, thoughts, or actions are not one's own but have been imposed by some external force.

. . .

grandiose delusion An exaggerated belief of one's importance, power, knowledge, or identity.

nihilisitic delusion A conviction of nonexistence of the self, part of the self, or others, or of the world. "I no longer have a brain" is an example.

persecutory delusion The conviction that one (or a group or institution close to one) is being harassed, attacked, persecuted, or conspired against.

somatic delusion A false belief involving the functioning of one's body, such as the conviction of a postmenopausal woman that she is pregnant, or a person's conviction that his nose is misshapen and ugly when there is nothing wrong with it.

. . .

denial A *defense mechanism*, operating unconsciously, used to resolve emotional *conflict* and allay *anxiety* by disavowing thoughts, feelings, wishes, needs, or external reality factors that are consciously intolerable.

depersonalization Feelings of unreality or strangeness concerning either the environment, the self, or both. This is characteristic of *depersonalization disorder* and may also occur in *schizotypal personality disorder, schizophrenia,* and in those persons experiencing overwhelming anxiety, stress, or fatigue.

depression When used to describe a mood, depression refers to feelings of sadness, despair, and discouragement. As such, depression may be a normal feeling state. The overt manifestations are highly variable and may be *culture specific.* Depression may be a *symptom* seen in a variety of mental or physical disorders, a *syndrome* of associated symptoms secondary to an underlying disorder, or a specific *mental disorder.* Slowed thinking, decreased pleasure, decreased purposeful physical activity, guilt and hopelessness, and disorders of eating and sleeping may be seen in the depressive syndrome. DSM-IV classifies depression by severity, recurrence, and association with *hypomania or mania.* Other categorizations divide depression into reactive and endogenous depressions on the basis of precipitants or symptom clusters. Depression in children may be indicated by refusal to go to school, *anxiety,* excessive reaction to separation from parental figures, antisocial behavior, and somatic complaints.

disruptive behavior disorder A disturbance of conduct severe enough to produce significant impairment in social, occupational, or academic functioning because of *symptoms* that range from oppositional defiant to moderate and severe conduct disturbances.

oppositional defiant symptoms may include losing temper; arguing with adults and actively refusing their requests; deliberately annoying others; blaming others for one's mistakes; being easily annoyed, resentful, or spiteful; and physically fighting with other members of the household.

conduct disturbance (moderate) symptoms may include truancy or work absences, alcohol or other substance use before the age of 13, stealing with confrontation, destruction of others' property, firesetting with intent of causing serious damage, initiating fights outside of home, and being physically cruel to animals.

conduct disturbance (severe) symptoms may include running away from home overnight at least twice, breaking into another's property, being physically cruel to people, stealing with confrontation, repeatedly using a dangerous weapon, and forcing someone into sexual activity.

dissociation The splitting off of clusters of mental contents from *conscious* awareness, a mechanism central to hysterical conversion and *dissociative disorder;* the separation of an idea from its emotional significance and affect as seen in the inappropriate *affect* of schizophrenic patients.

dysphoria Unpleasant mood.

dysthymic disorder One of the *depressive disorders*, characterized by a chronic course (i.e., seldom without symptoms) with lowered mood tone and a range of other symptoms that may include feelings of inadequacy, loss of self-esteem, or self-deprecation: feelings of hopelessness or despair; feelings of *guilt*, brooding about past events, or self-pity; low energy and chronic tiredness; being less active or talkative than usual; poor concentration and indecisiveness; and inability to enjoy pleasurable activities.

eating disorder Marked disturbance in eating behavior. In DSM-IV, this category includes *anorexia nervosa, bulimia nervosa,* and eating disorder not otherwise specified.

echolalia Parrot-like repetition of overheard words or fragments of speech. It may be part of a developmental disorder, a neurologic disorder, or *schizophrenia.* Echolalia tends to be repetitive and persistent and is often uttered with a mocking, mumbling, or staccato intonation.

encopresis, functional An elimination disorder in a child who is at least 4 years of age, consisting of repeated passage of feces into inappropriate places (clothing, floor, etc.) and not due to a *general medical condition.*

enuresis, functional An elimination disorder in a child who is at least 5 years of age, consisting of repeated voiding of urine into bed or clothing, not due to any general medical condition.

fetal alcohol syndrome A *congenital* disorder resulting from alcohol teratogenicity (i.e., the production, actual or potential, of pathological changes in the fetus, most frequently in the form of normal development of one or more organ systems; commonly referred to as birth defects), with the following possible dysmorphic categories: *central nervous system* dysfunction, birth deficiencies (such as low birth weight), facial abnormalities, and variable major and minor malformations. A safe level of alcohol use during pregnancy has not been established, and it is generally advisable for women to refrain from alcohol use during pregnancy.

fetishism One of the *paraphilias*, characterized by marked distress over, or acting on, sexual urges involving the use of nonliving objects (fetishes), such as underclothing, stockings, or boots.

flashback Hallucinogen persisting perception disorder or posthallucinogen perception disorder; reexperiencing, after ceasing the use of a hallucinogen, one or more of the perceptual symptoms that had been part of the hallucinatory experience while using the drug.

flight of ideas An early continuous flow of accelerated speech with abrupt changes from one topic to another, usually based on understandable associations, distracting stimuli, or playing on words. When severe, however, this may lead to disorganized and incoherent speech. Flight of ideas is characteristic of *manic episodes,* but it may occur also in *organic mental disorders, schizophrenia, other psychoses,* and, rarely, acute reactions to stress.

flooding(implosion) A behavior therapy procedure for phobias and other problems involving maladaptive anxiety, in which anxiety producers are presented in intense forms, either in imagination or in real life. The presentations, which act as desensitizers, are continued until the stimuli no longer produce disabling anxiety.

gender identity disorder One of the major groups of sexual and gender identity disorders, characterized by a strong and persistent identification with the opposite sex (cross-gender identification) and discomfort with one's assigned sex or a sense of inappropriateness in that gender role. Although onset is usually in childhood or adolescence, the disorder may not be presented clinically until adulthood. Manifestations include a repeated desire to be of the opposite sex, insistence that one has the typical feelings and reactions of the opposite sex, a belief that one was born the wrong sex, and transsexualism or preoccupation with one's primary and secondary sex characteristics in order to simulate the opposite sex.

hallucination A sensory perception in the absence of an actual external stimulus; to be distinguished from an *illusion*, which is a misperception or misinterpretation of an external stimulus. Hallucinations may involve any of the senses. . . .

hyperactivity Excessive motor activity that may be purposeful or aimless; movements and utterances are usually more rapid than normal. Hyperactivity is a prominent feature of attention-deficit disorder, so much so that in DSM-IV the latter is called *attention-deficit/ hyperactivity disorder (ADHD)*.

hypomania A psychopathological state and abnormality of *mood* falling somewhere between normal *euphoria* and *mania*. It is characterized by unrealistic optimism, pressure of speech and activity, and a decreased need for *sleep*. Some people show increased creativity during hypomanic states, whereas others show poor judgment, irritability and irascibility.

identity crisis A loss of the sense of the sameness and historical continuity of one's self and an inability to accept or adopt the role one perceives as being expected by society. This is often expressed by isolation, withdrawal, extremism, rebelliousness, and negativity, and is typically triggered by a sudden increase in the strength of instructional *drives* in a milieu of rapid social evolution and technological change.

impulse control disorders Failing to resist an *impulse*, drive, or temptation to perform some act that is harmful to oneself or to others. The impulse may be resisted consciously, but it is consonant with the person', immediate, *conscious* wish. The act may be premeditated or unplanned. The person may display regret or guilt for the action or its consequences. In DSM-IV, this category includes *pathological gambling, kleptomania, pyromania*, intermittent explosive disorder, and *trichotillomania*.

labile Rapidly shifting (as applied to *emotions*); unstable.

mania *Bipolar disorder;* a mood disorder characterized by excessive elation, inflated self-esteem and *grandiosity*, hyperactivity, agitation, and accelerated thinking and speaking. *Flight of ideas* may be present. A manic syndrome may also occur in *organic mental disorder,*.

-mania Formerly used as a nonspecific term for any type of "madness." Currently used as a suffix to indicate a morbid preoccupation with some kind of idea or activity, and/or a *compulsive* need to behave in some deviant way. Some examples are as follows:

egomania Pathological preoccupation with self.

. . .

kleptomania Compulsion to steal.

. . .

nymphomania Abnormal and excessive need or desire in the woman for sexual intercourse; see *satyriasis*.

pyromania Compulsion to set fires; an *impulse control disorder*.

trichotillomania Compulsion to pull one's own hair out; an *impulse disorder*.

manic episode A distinct period of time (usually lasting at least 1 week) of abnormally and persistently elevated, expansive, or irritable mood accompanied by such *symptoms* as inflated self-esteem or *grandiosity*, decreased need for sleep, overtalkativeness or *pressured speech*, *flight of ideas* or feeling that thoughts are racing, inattentiveness and distractibility, increased goal-directed activity (e.g., at work or school, socially or sexually), and involvement in pleasurable activities with high potential for painful consequences (e.g., buying sprees, sexual indiscretions, foolish business ventures). See *bipolar disorders*.

manic-depressive illness A term often used synonymously with *bipolar disorder*, as defined in DSM-IV.

mental health A state of being that is relative rather than absolute. The best indices of mental health are simultaneous success at working, loving, and creating, with the capacity for mature and flexible resolution of conflicts between *instincts*, *conscience*, important other people, and reality.

mental status examination The process of estimating psychological and behavioral function by observing the patient, eliciting his or her self-description, and using formal questioning. Included in the examination are 1) evaluation and assessment of any psychiatric condition present, including provisional *diagnosis and prognosis*, determination of degree of impairment, suitability for treatment, and indications for particular types of therapeutic intervention; 2) formulation of the personality structure of the subject, which may suggest the historical and developmental antecedents of whatever psychiatric condition exists; and 3) estimation of the subject's ability and willingness to participate appropriately in treatment. The mental status is reported in a series of narrative statements describing such things as *affect*, speech, thought content, perception, and *cognitive* functions. This examination is part of the general examination of all patients, although it may be markedly abbreviated in the absence of *psychopathology*.

mood disorders In DSM-IV, this category includes *depressive disorders*, *bipolar disorders*, *mood disorder due to a general medical condition*, and substance-induced (intoxication/ withdrawal) mood disorder.

mood swing Fluctuation of a person's emotional tone between periods of elation and periods of depression.

mutism, selective Elective mutism; a disorder of infancy, childhood, or adolescence characterized by persistent failure to speak in specific social situations by a child with demonstrated ability to speak. The mutism is not due to lack of fluency in the language being spoken or embarrassment about a speech problem.

negativistic personality disorder A type of *passive-aggressive personality disorder* characterized by passive resistance to demands for adequate social and occupational performance and a negative attitude. Typical manifestations include inefficiency, procrastination, complaints of being victimized and unappreciated, irritability, criticism of and scorn for authority, and personal discontent. The person with this disorder alternates between hostile assertions of independence and contrite, dependent behavior.

obsessive-compulsive disorder An *anxiety disorder* characterized by obsessions, compulsions, or both, that are time-consuming and interfere significantly with normal routine, occupational functioning, usual social activities, or relationships with others. See *compulsion; obsession*.

oppositional defiant order A patten of negativistic and hostile behavior in a child that lasts at least 6 months. *Symptoms* may include losing one's temper; arguing with adults or actively refusing their requests; deliberately annoying others; being easily annoyed, angry, and resentful; and being spiteful or vindictive.

overanxious disorder An anxiety disorder of childhood and adolescence, sometimes considered equivalent to the adult diagnosis of *generalized anxiety disorder*. Symptoms include multiple, unrealistic anxieties concerning the quality of one's performance in school and in sports; hobbies; money matters; punctuality; health; or appearance. The patient is tense and unable to relax and has recurrent somatic complaints for which no physical cause can be found.

panic attack A period of intense fear or discomfort, with the abrupt development of a variety of *symptoms* and fears of dying, going crazy, or losing control that reach a crescendo within 10 minutes. The symptoms may include shortness of breath or smothering sensations; dizziness, faintness, or feelings of unsteadiness; trembling or shaking; sweating; choking; nausea or abdominal distress; flushes or chills; and chest pain or discomfort.

Panic attacks occur in several *anxiety disorders*. In *panic disorder* they are typically unexpected and happen "out of the blue." In *social phobia* and *simple phobia* they are cued and occur when exposed to or in anticipation of a situational trigger. These attacks occur also in *posttraumatic stress disorder*.

phobia *Fear* cued by the presence or anticipation of a specific object or situation, exposure to which almost invariably provokes an immediate *anxiety* response or *panic attack* even though the subject recognizes that the fear is excessive or unreasonable. The phobic stimulus is avoided or endured with marked distress. In earlier psychoanalytic literature, phobia was called *anxiety hysteria*.

Two types of phobia have been differentiated: specific phobia (simple phobia) and social phobia. Specific phobia is subtyped on the basis of the object feared. The natural environment (animals, insects, storms, water, etc.); blood, injection, or injury; situations (cars, airplanes, heights, tunnels, etc.); and other situations that may lead to choking, vomiting, or contracting an illness are all specific phobias.

In social phobia (social anxiety disorder), the persistent fear is of social situations that might expose one to scrutiny by others and induce one to act in a way or show anxiety symptoms that will be humiliating or embarrassing. Avoidance may be limited to one or only a few situations, or it may occur in most social situations. Performing in front of others or social interactions may be the focus of concern. It is sometimes difficult to distinguish between social phobia and *agoraphobia* when social avoidance accompanies panic attacks. *Avoidant disorder* has been used to refer to social phobia occurring in childhood and adolescence.

Some of the common phobias are (add "abnormal fear of" to each entry):
achluophobia Darkness, **acrophobia** Heights, **agoraphobia** Open spaces or leaving the familiar setting of the home, **ailurophobia** Cats, **algophobia** Pain, **androphobia** Men, **autophobia** Being alone or solitude, **bathophobia** Depths, **claustrophobia** Closed spaces, **cynophobia** Dogs, **demophobia** Crowds, **erhthrophobia** Blushing; sometimes used to refer to the blushing itself, **gynophobia** Women, **hypnophobia** Sleep, **mysophobia** Dirt and germs, **panphobia** Everything, **pedophobia** Children, **xenophobia** Strangers

posttraumatic stress disorder (PTSD) An *anxiety disorder* in which exposure to an exceptional mental or physical stressor is followed, sometimes immediately and sometimes not until 3 months or more after the stress, by persistent reexperiencing of the event, avoidance of stimuli associated with the trauma or numbing of general responsiveness, and manifestations of increased arousal. The trauma typically includes experiencing, witnessing, or confronting an event that involves actual or threatened death or injury, or a threat to the physical integrity of oneself or others, with an immediate reaction of intense fear, helplessness, or horror.

Reexperiencing the trauma may take several forms: recurrent, intrusive, and distressing recollections (images, thoughts, or perceptions) of the event; recurrent distressing dreams of the event; sudden feeling as if the event were recurring or being relived (including dissociative flashback episodes); or intense psychological distress or physiological reactivity if exposed to internal or external cues that symbolize or resemble some part of the event.

The affected person tries to avoid thoughts or feelings associated with the event and anything that might arouse recollection of it. There may be *amnesia* for an important aspect of the trauma. The person may lose interest in significant activities, feel detached or estranged from others, or have a sense of a foreshortened future.

The person may have difficulty failing or staying asleep, be irritable or have angry outbursts, experience problems concentrating, and have an exaggerated startle response.

schizophrenia A group of idiopathic *psychotic disorders* characterized by both positive and negative *symptoms* associated with disturbance in one or more major areas of functioning such as work, academic development or achievement, interpersonal relations, and self-care. Positive symptoms include *delusions*, which may be bizarre in nature; hallucinations, especially auditory; disorganized speech; inappropriate *affect*; and disorganized behavior. Negative symptoms include flat affect, *avolition*, *alogia*, and *anhedonia*. Duration is variable: ICD-10 requires that continuous signs of the disturbance persist for at least 1 month; DSM-IV requires a minimum of 6 months.

separation anxiety disorder A disorder with onset before the age of 18 consisting of inappropriate *anxiety* concerning separation from home or from persons to whom the child is attached. Among the *symptoms* that may be seen are unrealistic concern about harm befalling or loss of major attachment figures; refusal to go to school (school phobia) in order to stay at home and maintain contact with this figure; refusal to go to *sleep* unless close to this person; clinging; nightmares about the theme of separation; and development of physical symptoms or mood changes (apathy, *depression*) when separation occurs or is anticipated.

sleep terror disorder One of the *parasomnias* characterized by *panic* and confusion when abruptly awakening from *sleep*. This usually begins with a scream and is accompanied by intense *anxiety*. The person is often confused and disoriented after awakening. No detailed dream is recalled, and there is *amnesia* for the episode. Sleep terrors typically occur during the first third of the major sleep episode. Contrast with *nightmare disorder*.

steroids, anabolic Synthetic derivatives of testosterone used medically to promote protein anabolism. They can be drugs of abuse used to aid in body building. They sometimes produce an initial sense of well-being replaced after repeated use by lack of energy, irritability, and unhappiness. Continued use may lead to such serious complications as severe *depression*, outbursts of violence, and liver disease.

systematic desensitization A *behavior therapy* procedure widely used to modify behaviors associated with *phobias*. The procedure involves the construction of a hierarchy of anxiety-producing stimuli by the subject, and gradual presentation of the stimuli until they no longer produce anxiety. Also called desensitization. See also *reciprocal inhibition*.

Tarasoff decision A California court decision that essentially imposes a duty on the therapist to warn the appropriate person or persons when the therapist becomes aware that the patient may present a risk of harm to a specific person or persons.

thought disorder A disturbance of speech, communication, or content of thought, such as *delusions*, *ideas of reference*, poverty of thought, *flight of ideas*, *preservation*, *loosening of associations*, and so forth. A thought disorder can be caused by a functional emotional disorder or an organic condition. A formal thought disorder is a disturbance in the form of thought rather than in the content of thought (e.g., loosening of associations).

tic An involuntary, sudden, rapid, recurrent, nonrhythmic stereotyped motor movement or vocalization. A tic may be an expression of an emotional conflict, the result of neurologic disease, or an effect of a drug (especially a stimulant or other *dopamine agonist*).

tic disorders In DSM-IV, this category includes *Tourette's disorder*, chronic motor or vocal tic disorder, transient tic disorder, and tic disorder not otherwise specified; all beginning before the age of 18 years. Chronic tics may occur many times a day, nearly every day, or intermittently over a period of more than a year. Transient tics do not persist for longer than 12 consecutive months.

Tourette's disorder A *tic disorder* consisting of multiple motor and vocal tics that occur in bouts, either concurrently or separately, almost every day or intermittently over a period of more than 12 months.

trichotillomania Pathological hair pulling that results in noticeable hair loss. As in other *impulse control disorders*, an increasing sense of tension or affective arousal immediately precedes an episode of hair pulling, which is then followed by a sense of pleasure, gratification, or relief.

Glossary of Acronyms and Laws For Special Educators Of Students with Emotional/Behavioral Disorders*

A

AABT	ASSOCIATION FOR THE ADVANCEMENT OF BEHAVIOR THERAPY
AACAP	AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY
AADA	ALCOHOL AND DRUG ABUSE
AASA	AMERICAN ASSOCIATION OF SCHOOL ADMINISTRATORS
ABA	AMERICAN BAR ASSOCIATION
	APPLIED BEHAVIOR ANALYSIS
	ASSOCIATION FOR BEHAVIOR ANALYSIS
A-B-C	ANTECEDENT-BEHAVIOR-CONSEQUENCE
ACA	AMERICAN COUNSELING ASSOCIATION
ACCH	ASSOCIATION FOR THE CARE OF CHILDREN'S HEALTH
ACLD	ASSOCIATION FOR CHILDREN WITH LEARNING DISABILITIES
ADA	AMERICANS WITH DISABILITIES ACT (P.L. 101-336,1990)
ADAA	ANTI-DRUG ABUSE ACT (P.L. 100-790,1988)
ADD	ATTENTION DEFICIT DISORDER
ADHD	ATTENTION DEFICIT/HYPERACTIVITY DISORDER
AFDC	AID TO FAMILIES WITH DEPENDENT CHILDREN
AMI-CAN	ALLIANCE FOR THE MENTALLY ILL-CHILD AND ADOLESCENT NETWORK
AOA	AMERICAN ORTHOPSYCHIATRIC ASSOCIATION
APA	AMERICAN PSYCHIATRIC ASSOCIATION
	AMERICAN PSYCHOLOGICAL ASSOCIATION
APE	ADAPTIVE PHYSICAL EDUCATION
ARC	ASSOCIATION FOR RETARDED CITIZENS
ASA	AUTISM SOCIETY OF AMERICA

B

BD	BEHAVIOR/BEHAVIORAL DISORDER/DISORDERED
BIP	BEHAVIOR INTERVENTION PLAN
BMOD	BEHAVIOR MODIFICATION
BP	BEHAVIOR PROBLEM(S)

BEST COPY AVAILABLE

C

CAP	CLIENT ASSISTANCE PROGRAM
	COMMUNITY ACTION PROGRAM
CAPP	COLLABORATION AMONG PARENTS & HEALTH PROFESSIONALS
CASE	COUNCIL FOR ADMINISTRATORS OF SPECIAL EDUCATION (CEC)
CASSP	CHILD & ADOLESCENT SERVICE SYSTEM PROGRAM
CAT	CALIFORNIA ACHIEVEMENT TEST
	CHILDRENS APPERCEPTION TEST
	COGNITIVE ABILITIES TEST
	CONSULTATION ASSISTANCE TEAM
CBA	CURRICULUM-BASED ASSESSMENT
CBCL	CHILD BEHAVIOR CHECKLIST (ACHENBACH)
CBE	CURRICULUM-BASED EVALUATION
CBM	CURRICULUM-BASED MEASUREMENT
CCBD	COUNCIL FOR CHILDREN WITH BEHAVIORAL DISORDERS (CEC)
CD	CHEMICALLY DEPENDENT
	CONDUCT DISORDER
CDC	CENTER FOR DISEASE CONTROL
CDF	CHILDREN'S DEFENSE FUND
CE	CAREER EDUCATION
CEC	COUNCIL FOR EXCEPTIONAL CHILDREN
CER	CONDITIONED EMOTIONAL RESPONSE
CFS	CHILDREN AND FAMILY SERVICES
CHADD	CHILDREN WITH ATTENTION DEFICIT DISORDER
CHEN	COMMUNITY HEALTH EDUCATION NETWORK
CHINS	CHILDREN IN NEED OF SERVICES
CHIPS	CHIDREN IN NEED OF PROTECTIVE SERVICES
CMHC	COMMUNITY MENTAL HEALTH CENTER
CMHSP	CHILDREN'S MENTAL HEALTH SERVICES PROGRAM (P.L. 102-321)
CLD	CULTURALLY AND LINGUISTICALLY DIVERSE
CLDES	CULTURALLY AND LINGUISTICALLY DIVERSE EXCEPTIONAL STUDENTS
COH	COMMITTEES OF THE HANDICAPPED
CPS	CHILD PROTECTIVE SERVICES
CRF	CONTINUOUS REINFORCEMENT SCHEDULE
CRS	CONNERS'RATING SCALES

CSE	COMMITTEE ON SPECIAL EDUCATOIN
CSP	COMMUNITY SUPPORT PROGRAM
CSSP	COMMUNITY SOCIAL SERVICES PROGRAM
CST	CHILD STUDY TEAM
CTIC	COMMUNITY TRANSITION INTERAGENCE COMMITTEE
CWLA	CHILD WELFARE LEAGUE OF AMERICA

D

DCCD	DIVISION FOR CHILDREN WITH COMMUNICATION DISORDERS (CEC)
DD	DEVELOPMENTAL DISABILITIES
	DUALLY DIAGNOSED (e.g. EBD & CHEMICAL ABUSE)
DDEL	DIVISION FOR CULTURALLY AND LINGUISTICALLY DIVERSE EXCEPTIONAL LEARNERS(CEC)
DEC	DIVISION OF EARLY CHILDHOOD (CEC)
DHS	DEPARTMENT OF HUMAN SERVICES
DISES	DIVISION OF INTERNATIONAL SPECIAL EDUCATION SERVICES (CEC)
DLD	DIVISION FOR LEARNING DISABILITIES (CEC)
DOE	DEPARTMENT OF EDUCATION
DR(O,A,H,I)	DIFFERENTIAL REINFORCEMENT PROCEDURES (OTHER, ALTERNATE, HIGH RATES, INCOMPATIBLE --BEHAVIORS)
DREDF	DISABILITY RIGHTS EDUCATION AND DEFENSE FUND
DRS	DEPARTMENT OF REHABILITATION SERVICES
DSM	DIAGNOSTIC AND STATISTICAL MANUAL (1994 DSM-IV)
DTP	DAY TREATMENT PROGRAMS
DVH	DIVISION ON VISUAL HANDICAPS (CEC)
DVR	DIVISION OF VOCATIONAL REHABILITATION (DEPT OF JOBS & TRAINING)

E

EAHC	EDUCATION FOR ALL HANDICAPPED CHILDREN ACT (P.L. 94-142,1975) AMENDED (P.L. 99-457,1986-INFANTS/TODDLER PROGRAMS)
EBD	EMOTIONAL BEHAVIORAL DISORDERS
ECFE	EARLY CHILDHOOD FAMILY EDUCATION
ECSE	EARLY CHILDHOOD SPECIAL EDUCATION
EDGAR	EDUCATION GENERAL ADMINISTRATIVE REGULATIONS
EEOC	EQUAL EMPLOYMENT OPPORTUNITY COMMISSION (U.S.)
EH	EMOTIONALLY HANDICAPPED

EHA	EDUCATION OF THE HANDICAPPED ACT (PART B, PL 94-142)
EI	EMOTIONALLY IMPAIRED
EMH	EDUCABLE MENTALLY HANDICAPPED
EMR	EDUCABLE MENTALLY RETARDED
EPSDT'	EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT
ERIC	EDUCATIONAL RESEARCH AND IMPROVEMENT CENTER
	EDUCATIONAL RESOURCE INFORMATION CENTER
ERT	EDUCATIONAL RESOURCE TEACHER
ESEA	ELEMENTARY AND SECONDARY EDUCATION ACT (I 965)
ESL	ENGLISH AS A SECOND LANGUAGE
ETS	EDUCATIONAL TESTING SERVICE

F

FA	FAMILIES ANONYMOUS
FAPE	FREE APPROPRIATE PUBLIC EDUCATION
FAS	FETAL ALCOHOI. SYNDROME
FCSS	FAMILY COMMUNITY SUPPORT SERVICES
FERPA	FAMILY EDUCATIONAL RIGHTS and PRIVACY ACT
FFCM	FEDERATION OF FAMILIES FOR CHILDREN'S MENTAL HEALTH
FFTA	FOSTER FAMILY-BASED TREATMENT ASSOCIATION
FICC	FEDERAL INTERAGENCY COORDINATING COUNCIL
FSA	FAMILY SERVICES OF AMERICA
FYSB	FAMILY & YOUTH SERVICE BUREAU (U.S. DEPT. OF HEALTH & HUMAN SERVICES)

G

GA/EA	GENERAL ASSISTANCE/EMERGENCY ASSISTANCE
GATE	GIFTED AND TALENTED EDUCATION
GE	GRADE EQUIVALENT
GED	GENERAL EDUCATION DIPLOMA

H

HCPA	HANDICAPPED CHILDRENS PROTECTION ACT (P.L. 99-372, 1986, AMENDMENT TO P.L. 94-142)
HEATH	HIGHER EDUCATION AND THE HANDICAPPED
HECB	HIGHER EDUCATION COORDINATING BOARD
HEW	HEALTH EDUCATION AND WELFARE

HHS	HEALTH AND HUMAN SERVICES
HI	HEARING IMPAIRED
HIO	HEALTH INSURANCE ORGANIZATION
HMO	HEALTH MAINTENANCE ORGANIZATION

I

IASA	IMPROVING AMERICA'S SCHOOLS ACT
IARET	INTERNATIONAL ASSOCIATION FOR THE RIGHT TO EFFECTIVE TREATMENT
ICC	INTERAGENCY COORDINATING COUNCIL
ICD	INTERNATIONAL CLASSIFICATION SYSTEM
ICF	INTERMEDIATE CARE FACILITY
ICP	INDIVIDUAL CAREER PLAN
IDEA	INDIVIDUALS WITH DISABILITIES EDUCATION ACT (P.L.101-457,1990, AMENDMENTS TO P.L. 94-142)
IDT	INTER-DISCIPLINARY TEAM
IEE	INDEPENDENT EDUCATIONAL EVALUATION
IEIC	INTERAGENCY EARLY INTERVENTION COMMITTEE
IEP	INDIVIDUALIZED EDUCATION PLAN/PROGRAM
IEU	INTERMEDIATE EDUCATIONAL UNIT
IFCSP	INDIVIDUAL FAMILY COMMUNITY SUPPORT PLAN
IFSP	INDIVIDUALIZED FAMILY SERVICES PLAN
IHE	INSTITUTION OF HIGHER EDUCATION
IHP	INDIVIDUAL HABILITATION PLAN
IIP	INDIVIDUALIZED INSTRUCTIONAL PLAN
ILP	INDIVIDUAL LEARNING PLAN
IMS	INFORMATIONAL MANAGEMENT SYSTEM INSTRUCTIONAL MANAGEMENT SYSTEM
IPP	INDIVIDUALIZED PROGRAM PLAN
IQ	INTELLIGENCE QUOTIENT
I&R	INFORMATION AND REFERRAL
ISD	INDEPENDENT SCHOOL DISTRICT
ISP	INDIVIDUALIZED SERVICES PLAN
ITP	INDIVIDUALIZED TRANSITION PLAN INDIVIDUALIZED TREATMENT PLAN

J

JD	JUVENILE DELINQUENT
JJ	JUVENILE JUSTICE
JJDPA	JUVENILE JUSTICE AND DELINQUENCY PREVENTION ACT (P.L. 93-415,1974)
JOBS	JOB OPPORTUNITIES AND BASIC SKILLS
JTPA	JOB TRAINING PARTNERSHIP ACT (P.L. 97-300,1983)
JWB	JUVEINLE WELFARE BOARD

K

KTEA	KAUFMAN TEST OF EDUCATIONAL ACHIEVEMENT

L

LAC	LOCAL ADVISORY COUNCIL (MENTAL HEALTH)
LCC	LOCAL COORDINATING COUNCIL (MENTAL HEALTH)
LCP	LICENSED CONSULTING PSYCHOLOGIST
LD	LEARNING DISABLED
LEA	LOCAL EDUCATION AGENCY
LEP	LIMITED ENGLISH PROFICIENCY
LI	LOW INCIDENCE HANDICAPPING CONDITION
LIA	LOCAL INTERAGENCY AGREEMENT
LRA	LEAST RESTRICTIVE ALTERNATIVE
LRE	LAW RELATED EDUCATION
	LEAST RESTRICTIVE ENVIRONMENT
LST	LEARNER SUPPORT TEAM
LSW	LICENSED SOCIAL WORKER
LTM	LONG TERM MEMORY

M

MA	MEDICAL ASSISTANCE
	MENTAL AGE
MCH	MATERNAL AND CHILD HEALTH
MDC	MULTI-DISCIPLINARY COMMITTEE
MDT	MULTI-DISCIPLINARY TEAM
MH	MENTAL HANDICAP
MI	MENTAL ILLNESS/MENTALLY ILL
	MENTALLY IMPAIRED

MMPI	MINNESOTA MULTIPHASIC PERSONALITY INVENTORY
MR	MENTALLY RETARDED
N	
NACA	NATIONAL ASSOCIATION OF CHILD ADVOCATES
NACHC	NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS
NADAP	NATIONAL ASSOCIATION ON DRUG ABUSE PROBLEMS, INC
NAESP	NATIONAL ASSOCIATION OF ELEMENTARY SCHOOL PRINCIPALS
NAHC	NATIONAL ASSOCIATION OF HOMES FOR CHILBREN
NAMI	NATIONAL ALLIANCE FOR THE MENTALLY ILL
NAPAS	NATIONAL ASSOCIATION OF PROTECTION AND ADVOCACY SYSTEMS
NAPPH	NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS
NAPSEC	NATIONAL ASSOCIATION OF PRIVATE SCHOOLS FOR EXCEPTIONAL CHILDREN
NAPTCC	NATIONAL ASSOCIATION OF PSYCHIATRIC TREATMENT CENTERS FOR CHILDREN
NARF	NATIONAL ASSOCIATION OF REHABILITATION FACILITIES
NASADAD	NATIONAL ASSOCIATION OF STATE ALCOHOL AND DRUG ABUSE DIRECTORS
NASB	NATIONAL ASSOCIATION OF SCHOOL BOARDS
NASBE	NATIONAL ASSOCIATION OF STATE BOARDS OF EDUCATION
NASMHPD	NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS
NASDSE	NATIONAL ASSOCIATION OF STATE DIRECTORS OF SPECIAL EDUCATION
NASNSA	NATIONAL ASSOCIATION OF SPECIAL NEEDS STATE ADMINISTRATORS
NASP	NATIONAL ASSOCIATION OF SCHOOL PSYCHOLOGISTS
NASDE	NATIONAL ASSOCIATION OF STATE DIRECTORS OF SPECIAL EDUCATION
NASSP	NATIONAL ASSOCIATION OF SECONDARY SCHOOL PRINCIPALS
NASW	NATIONAL ASSOCIATION OF SOCIAL WORKERS
NAVESNP	NATIONAL ASSOCIATION OF VOCATIONAL EDUCATION SPECIAL NEEDS PERSONNEL
NCAS	NATIONAL COALITION OF ADVOCATES FOR STUDENTS
NCBE	NATIONAL CLEARINGHOUSE FOR BILINGUAL EDUCATION
NCCAFV	NATIONAL COUNCIL ON CHILD ABUSE AND FAMILY VIOLENCE
NCLH	NATIONAL CENTER FOR LAW AND THE HANDICAPPED
NDPC	NATIONAL DROPOUT PREVENTION CENTER
NEA	NATIONAL EDUCATION ASSOCIATION
NFB	NATIONAL FEDERATION OF THE BLIND
NFP	NOT-FOR-PROFIT

NICHCY	NATIONAL INFORMATION CENTER FOR HANDICAPPED CHILDREN AND YOUTH
NIDA	NATIONAL INSTITUTE ON DRUG ABUSE
NIDDR	NATIONAL INSTITUTE ON DISABILITY REHABILITATION RESEARCH
NIH	NATIONAL INSTITUTE OF HEALTH
NIMH	NATIONAL INSTITUTE OF MENTAL HEALTH
NMHA	NATIONAL MENTAL HEALTH ASSOCIATION
NMHCA	NATIONAL MENTAL HEALTH CONSUMERS ASSOCIATION
NMSA	NATIONAL MIDDLE SCHOOL ASSOCIATION
NNPC	NATIONAL NETWORK OF PARENT CENTERS
NNRYS	NATIONAL NETWORK OF RUNAWAY AND YOUTH SERVICES
NOCCWA	NATIONAL ORGANIZATION OF CHILD CARE WORKERS ASSOCIATION
NRCCAN	NATIONAL RESOURCE CENTER FOR CHILD ABUSE AND NEGLECT
NSAC	NATIONAL SOCIETY FOR CHILDREN & ADULTS WITH AUTISM

O

OBE	OUTCOME-BASED EDUCATION
OCD	OBSESSIVE COMPULSIVE DISORDER
OCR	OFFICE OF CIVIL RIGHTS
ODD	OPPOSITIONAL DEFIANT DISORDER
OERI	OFFICE OF EDUCATIONAL RESEARCH AND IMPROVEMENT
OH	ORTHOPEDICALLY HANDICAPPED
OHI	OTHER HEALTH IMPAIRMENTS
OJJDP	OFFICE OF JUVENILE JUSTICE AND DELINQUENCY PREVENTION
OJT	ON-THE-JOB TRAINING
OMB	OFFICE OF MANAGEMENT AND BUDGET
OSEP	OFFICE OF SPECIAL EDUCATION PROGRAMS (FEDERAL)
OSERS	OFFICE OF SPECIAL EDUCATION & REHABILITATIVE SERVICES
OT	OCCUPATIONAL THERAPIST/THERAPY

P

PA	PARENTS ANONYMOUS
P&A	PROTECTION AND ADVOCACY (SYSTEM)
PDD	PERVASIVE DEPRRIVATION DISORDER PERVASIVE DEVELOPMENTAL DISORDER
PDR	PHYSICIANS DESK REFERENCE
PE	PHYSICAL EDUCATION

PH	PHYSICALLY HANDICAPPED
PKU	PHENYLKETONURIA
P.L.	PUBLIC LAW
PMC	PARENT OF A MINOR CARETAKER (FOR AFCD)
POHI	PHYSICAL AND OTHER HEALTH IMPAIRED
PPT	PUPIL PERSONNEL TEAM
PSEN	PUPILS WITH SPECIAL EDUCATION NEEDS
PSS	PRESCHOOL SCREENING PROGRAM
PT	PHYSICAL THERAPIST,
PTA	PARENT TEACHER ASSOCIATION
PTIC	PARENT TRAINING AND INFORMATION CENTER
PTO	PARENT TEACHER ORGANIZATION
PTSA	PARENT TEACHER STUDENT ASSOCIATION
PTSD	POST TRAUMATIC STRESS DISORDER

Q

R

RCF	RESIDENTIAL CARE FACILITY
R&D	RESEARCH AND DEVELOPMENT
RE-ED	RE-EDUCATION
RET	RATIONAL EMOTIVE THERAPY
RHVA	RUNAWAY AND HOMELESS YOUTH ACT (P.L. 96-509.1980)
RISC	REGIONAL INTERAGENCY SYSTEMS CHANGE PROJECTS
RSA	REHABILITATION SERVICES ADMINISTRATION
RT	RECREATION THERAPY
RTC	RESIDENTIAL TREATMENT CENTER
SAMHSA	SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION
SBST	SCHOOL-BASED SUPPORT TEAM
SAT	SCHOLASTIC APTITUDE TEST
SCH	SERVICES TO CHILDREN WITH HANDICAPS
	STATE COUNCIL FOR THE HANDICAPPED
SDE	STATE DEPARTMENT OF EDUCATION
SE	SPECIAL EDUCATION
	SUPPORTED EMPLOYMENT
SEA	STATE EDUCATION AGENCY

SEAC	SPECIAL EDUCATION ADVISORY COMMITTEES
SED	SERIOUS EMOTIONAL DISTURBANCE
	SERIOUSLY EMOTIONALLY DISTURBED
SEDNET	SERIOUS EMOTIONAL DISTURBANCE NETWORK
	SPECIAL EDUCATION NETWORK TEAM
SEEC	SPECIAL EDUCATION EARLY CHILDHOOD
SEP	SPECIAL EDUCATION PROGRAMS (OFFICE OF)
SERT	SPECIAL EDUCATION RESOURCE TEACHER
SH	SEVERELY HANDICAPPED
SIB	SELF-INJURIOUS BEHAVIOR
SIDS	SUDDEN INFANT-DEATH SYNDROME
SLA	SUPPORTED LIVING ARRANGEMENT
SLBP	SPECIAL LEARNING AND BEHAVIOR PROBLEMS
SLD	SPECIFIC LEARNING DISABILITY
SM	SOCIALLY MALADJUSTED
SMHRCY	STATE MENTAL HEALTH REPRESENTATIVE FOR CHILDREN AND YOUTH
SOP	STATE OPERATED PROGRAMS
SPED	SPECIAL EDUCATION
SR, S-R	STIMULUS-RESPONSE
SSA	SOCIAL SECURITY ADMINISTRATION
SSI	SUPPLEMENTAL SECURITY INCOME
SST	STUDENT SUPPORT TEAM
ST	SPEECH THERAPIST
STAR	SYSTEM OF TECHNOLOGY TO ACHIEVE RESULTS
STIC	STATE TRANSITION INTERAGENCY COMMITTEE
STM	SHORT TERM MEMORY
SW	SHELTERED WORKSHOP
	SOCIAL WORKER

T

TA	TECHNICAL ASSISTANCE
TAG	THE ASSOCIATION FOR THE GIFTED (CEC)
TAM	TECHNOLOGY AND MEDIA DIVISION (CEC)
TAPP	TECHNICAL ASSISTANCE TO PARENT PROGRAMS
TASH	THE ASSOCIATION FOR PERSONS WITH SEVERE HANDICAPS
TAT	TEACHER ASSISTANCE TEAM

TBI	TRAMATIC BRAIN INJURY
TDD	TELECOMMUNICATION DEVICE FOR THE DEAF
TED	TEACHER EDUCATION DIVISION (CEC)
TMH	TRAINABLE MENTALLY HANDICAPPED
TMR	TRAINABLE MENTALLY RETARDED
TSES	TOTAL SPECIAL EDUCATION SYSTEM
TT	TECHNICAL TUTOR
TTY	TELETYPEWRITER
U	
UAP	UNIVERSITY AFFILIATED PROGRAM
UPC	UNITED CEREBAL PALSY
USOE	UNITED STATES OFFICE OF EDUCATION
V	
VAC	VOCATIONAL ADJUSTMENT COUNSELOR
VE	VOCATIONAL EDUCATION
VH	VISUALLY HANDICAPPED
VI	VISUAL IMPAIRMENT
WIC	WOMEN INFANTS AND CHILDREN (NUTRITION PROGRAM)
WIS	WELFARE INFORMATION SYSTEM I
WS	WAIVERED SERVICES
Z	
Z	STANDARD TEST SCORE

Federal Laws

P.L. 89-313 EDUCATION TO IMPROVE OPPORTUNITIES FOR LOW-INCOME UNDERACHIEVERS (CHAPTER 1, TITLE 1)

P.L. 91-230 THE EDUCATION OF THE HANDICAPPED ACT, 1970

P.L. 90-247 PRIVACY RIGHTS OF PARENTS AND STUDENTS IN STATE ADMINISTERED PROGRAMS

P.L. 93-112 SECTION 503-AFFIRMATIVE ACTION FOR EMPOLYMENT, AND 504-PROHIBITS DISCRIMINATION BASED ON HANDICAP, OF REHABILITATION ACT 1973

P.L. 93-415 JUVENILE JUSTICE AND DELINQUENCY PREVENTION ACT, 1974

P.L. 94-142 EDUCATION FOR ALL HANDICAPPED CHILDRENS' ACT, 1975

P.L. 94-482 VOCATIONAL EDUCATION AMENDMENTS, 1976

P.L. 97-35 CHAPTER 1 CONSOLIDATION AND IMPROVEMENT ACT, 1982

P.L. 97-248 TAX EQUITY AND FISCAL RESPONSIBILITY ACT, 1982

P.L. 97-300 JOB TRAINING PARTNERSHIP ACT, 1983

P.L. 98-524 CARL PERKINS ACT, 1984

P.L. 99-372 HANDICAPPED CHILDREN'S PROTECTION ACT, 1986

P.L. 99-457 EHA AMENDMENTS FOR INFANTS AND TODDLERS, 1986

P.L. 100-790 ANTI-DRUG ABUSE ACT, 1988

P.L. 101-336 AMERICANS WITH DISABILITIES ACT, 1990

P.L. 101-476 INDIVIDUALS WITH DISABILITIES ACT, 1990

P.L. 102-321 CHILDREN'S MENTAL HEALTH SERVICES PROGRAM

GLOSSARY

Children's and Adolescents' Mental Health: A Glossary of Terms

This glossary contains terms used frequently when dealing with the mental health needs of children. The list is alphabetical. Words highlighted by *italics* have their own separate definitions. The term *service* or *services* is used frequently in this glossary. The reader may wish to look up *service* before reading the other definitions.

The terms in this glossary describe ideal services. This help may not be available in all communities. The Comprehensive Community Mental Health Services for Children Program, administered by the Center for Mental Health Services (CMHS), has 22 grantees in 18 States that are demonstrating these services. For more information about children's mental health issues or services, call the CMHS National Mental Health Services Knowledge Exchange Network (KEN): 1.800.789.2647.

Accessible Services — Services that are affordable, located nearby, and are open during evenings and weekends. Staff is sensitive to and incorporates individual and cultural values. Staff is also sensitive to barriers that may keep a person from getting help. For example, an adolescent may be more willing to attend a support group meeting in a church or club near home, rather than travel to a mental health center. An accessible service can handle consumer demand without placing people on a long waiting list.

Appropriate Services — Designed to meet the specific needs of each individual child and family. For example, one family may need *day treatment* services while another family may need *home-based services*. Appropriate services for one child or family may not be appropriate for another family. Usually the most appropriate services are in the child's community.

Assessment — A professional review of a child's and family's needs that is done when they first seek services from a *caregiver*. The assessment of the child includes a review of physical and mental health, intelligence, school performance, family situation, and behavior in the community. The assessment identifies the strengths of the child and family. Together, the *caregiver* and family decide what kind of treatment and supports, if any, are needed.

Caregiver — A person who has special training to help people with mental health problems. Examples of people with this special training are social workers, teachers, psychologists, psychiatrists, and mentors.

Case Manager — An individual who organizes and coordinates services and supports for children with mental health problems and their families. (Alternate terms: service coordinator, advocate, and facilitator.)

Case Management — A service that helps people arrange *appropriate and available services* and supports. As needed, a *case manager* coordinates mental health, social work, education, health, vocational, transportation, advocacy, *respite*, and recreational services. The *case manager* makes sure that the child's and family's changing needs are met. (This definition does not apply to *managed care*.)

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration • Center for Mental Health Services
5600 Fishers Lane, Room 13-103 • Rockville, Maryland 20857 • Telephone 301 443 2792

CARING FOR EVERY CHILD'S MENTAL HEALTH: Communities Together Campaign

For information about children's mental health, contact the CMHS Knowledge Exchange Network
PO Box 42490 • Washington, DC 20015 • Toll-free 1 800 789 2647 • FAX 302 656 4012
FAX 301 984 8796 • TTY 301 443 9006 • CMHS Electronic Bulletin Board 1 800 790 2647

SAMHSA

BEST COPY AVAILABLE

Child Protective Services — Designed to safeguard the child when there is suspicion of abuse, neglect, or abandonment, or where there is no family to take care of the child. Examples of help delivered in the home include financial assistance, vocational training, homemaker services, and day care. If in-home supports are insufficient, the child may be removed from the home on a temporary or permanent basis. The goal is to keep the child with his or her family whenever possible.

Children and Adolescents at Risk for Mental Health Problems — Children at higher risk for developing mental health problems when certain factors occur in their lives or environment. Some of these factors are physical abuse, emotional abuse or neglect, harmful stress, discrimination, poverty, loss of loved one, frequent moving, alcohol and other drug use, trauma, and exposure to violence.

Continuum of Care — A term that implies a progression of services that a child would move through, probably one at a time. The more up-to-date idea is one of comprehensive services. See *systems of care* and *wraparound services*.

Coordinated Services — Child-serving organizations, along with the family, talk with each other and agree upon a *plan of care* that meets the child's needs. These organizations can include mental health, education, juvenile justice, and child welfare. *Case management* is necessary to coordinate services. (Also see *family-centered services* and *wraparound services*.)

Crisis Residential Treatment Services — Short-term, round-the-clock help provided in a non-hospital setting during a crisis. For example, when a child becomes aggressive and uncontrollable despite in-home supports, the parent can have the child temporarily placed in a *crisis residential treatment service*. The purpose of this care is to avoid *inpatient hospitalization*, to help stabilize the child, and to determine the next appropriate step.

Cultural Competence — Help that is sensitive and responsive to cultural differences. *Caregivers* are aware of the impact of their own culture and possess skills that help them provide services that are culturally appropriate in responding to people's unique cultural differences, such as race and ethnicity, national origin, religion, age, gender, sexual orientation, or physical disability. They adapt their skills to fit a family's values and customs.

Day Treatment — Day treatment includes special education, counseling, parent training, vocational training, skill building, crisis intervention, and recreational therapy. It lasts at least 4 hours a day. Day treatment programs work with mental health, recreation, and education organizations and may be provided by them.

DSM-IV (*Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition) — An official manual of mental health problems developed by the American Psychiatric Association. This reference book is used by psychiatrists, psychologists, social workers, and other health and mental health care providers to understand and diagnose a mental health problem. Insurance companies and health care providers also use the terms and explanations in this book when they discuss mental health problems.

Early Intervention — A process for recognizing warning signs that individuals are at risk for mental health problems and taking early action against factors that put them at risk. Early intervention can help children get better more quickly and prevent problems from becoming worse.

Emergency and Crisis Services — A group of services that are available 24 hours a day, 7 days a week, to help during a mental health emergency. When a child is thinking about suicide, these services could save his or her life. Examples: telephone crisis hotlines, crisis counseling, *crisis residential treatment services*, crisis outreach teams, and crisis respite care.

Family-Centered Services — Help designed for the specific needs of each individual child and his or her family. Children and families should not be expected to fit into services that don't meet their needs. See *appropriate services, coordinated services, wraparound services,* and *cultural competence.*

BEST COPY AVAILABLE

Family Support Services — Help designed to keep the family together and to cope with mental health problems that affect them. These services may include consumer information workshops, in-home supports, family therapy, parent training, *crisis services*, and *respite care*.

Home-Based Services — Help provided in a family's home for either a defined time or for as long as necessary to deal with a mental health problem. Examples include parent training, counseling, and working with family members to identify, find, or provide other help they may need. The goal is to prevent the child from being placed out of the home. (Alternate term: in-home supports.)

Independent Living Services — Support for a young person in living on his or her own and in getting a job. These services can include *therapeutic group care* or supervised apartment living. Services teach youth how to handle financial, medical, housing, transportation, and other daily living needs, as well as how to get along with others.

Individualized Services — Designed to meet the unique needs of each child and family. Services are individualized when the *caregivers* pay attention to the child's and family's needs and strengths, ages, and stages of development. See *appropriate services* and *family-centered services*.

Inpatient Hospitalization — Mental health treatment in a hospital setting 24 hours a day. The purpose of inpatient hospitalization is: (1) short-term treatment in cases where a child is in crisis and possibly a danger to self or others, and (2) diagnosis and treatment when the patient cannot be evaluated or treated appropriately in an outpatient setting.

Managed Care — A way to supervise the delivery of health care services. Managed care may specify the *caregivers* that the insured family can see. It may also limit the number of visits and kinds of services that will be covered.

Mental Health — Mental health refers to how a person thinks, feels, and acts when faced with life's situations. It is how people look at themselves, their lives, and the other people in their lives; evaluate the challenges and the problems; and explore choices. This includes handling stress, relating to other people, and making decisions.

Mental Health Problems — Mental health problems are real. These problems affect one's thoughts, body, feelings, and behavior. They can be severe. They can seriously interfere with a person's life. They're not just a passing phase. They can cause a person to become disabled. Some of these disorders are known as depression, bipolar disorder (manic-depressive illness), attention deficit hyperactivity disorder, anxiety disorders, eating disorders, schizophrenia and conduct disorder.

Mental Disorders — Another term used for *mental health problems*.

Mental Illnesses — This term is usually used to refer to severe mental health problems in adults.

Plan of Care — A treatment plan designed for each child or family. The *caregiver(s)* develop(s) the plan with the family. The plan identifies the child's and family's strengths and needs. It establishes goals and details appropriate treatment and services to meet his or her special needs.

Residential Treatment Centers — Facilities that provide treatment 24 hours a day and can usually serve more than 12 young people at a time. Children with *serious emotional disturbances* receive constant supervision and care. Treatment may include individual, group, and family therapy; behavior therapy; special education; recreation therapy; and medical services. Residential treatment is usually more long-term than *inpatient hospitalization*. Centers are also known as *therapeutic group homes*.

Respite Care — A service that provides a break for parents who have a child with a *serious emotional disturbance*. Some parents may need this help every week. It can be provided in the home or in another

BEST COPY AVAILABLE

location. Trained parents or counselors take care of the child for a brief period of time. This gives families relief from the strain of taking care of a child with a serious emotional disturbance.

Serious Emotional Disturbance — Diagnosable disorders in children and adolescents that severely disrupt daily functioning in the home, school, or community. Some of these disorders are depression, attention-deficit/ hyperactivity, anxiety, conduct, and eating disorders. Serious emotional disturbances affect 1 in 20 young people.

Service — A type of support or clinical intervention designed to address the specific mental health needs of a child and his or her family. A service could be received once or repeated over a course of time as determined by the child, family, and service provider.

System of Care — A method of delivering mental health services that helps children and adolescents with mental health problems and their families get the full range of services in or near their homes and communities. These services must be tailored to each individual child's physical, emotional, social, and educational needs. In systems of care, local organizations work in teams to provide these services.

Therapeutic Foster Care — A home where a child with a *serious emotional disturbance* lives with trained foster parents with access to other support services. These foster parents receive special support from organizations that provide crisis intervention, psychiatric, psychological, and social work services. The intended length of this care is usually from 6 to 12 months.

Therapeutic Group Homes — Community-based, home-like settings that provide intensive treatment services to a small number of young people (usually 5 to 10 persons). These young people work on issues that require 24-hour-per-day supervision. The home should have many connections within an interagency *system of care*. Psychiatric services offered in this setting try to avoid hospital placement and to help the young person move toward a less restrictive living situation.

Transitional Services — Services that help children leave the system that provides help for children and move into adulthood and the adult service system. Help includes mental health care, *independent living services*, supported housing, vocational services, and a range of other support services.

Wraparound Services — A "full-service" approach to developing help that meets the mental health needs of individual children and their families. Children and families may need a range of community support services to fully benefit from traditional mental health services such as family therapy and special education. See *appropriate services, coordinated services, family-centered services,* and *system of care*.

Important Messages About Children's and Adolescents' Mental Health:

- Every child's mental health is important.
- Many children have mental health problems.
- These problems are real and painful and can be severe.
- Mental health problems can be recognized and treated.
- Caring families and communities working together can help.
- Information is available; call 1.800.789.2647.

For free information about children's and adolescents' mental health—including publications, references, and referrals to local and national resources and organizations—call 1.800.789.2647; TTY 301.443.9006.

3.14.96

BEST COPY AVAILABLE

Continuing Education

ADDRESSING BARRIERS TO LEARNING: NEW DIRECTIONS FOR MENTAL HEALTH IN SCHOOLS

Instructor's Guide
and
Test Questions & Answers

Prepared by the School Mental Health Project/Center for Mental Health in Schools, Dept. of Psychology, UCLA, Los Angeles, CA 90095-1563 -- (310) 825-3634. Co-directors: Howard Adelman & Linda Taylor

Support comes in part from the Dept. of Health and Human Services, Public Health Service, Health Resources and Services Administration, Maternal and Child Health Bureau, Office of Adolescent Health.

PREFACE

There is a simple truth that every professional working in schools knows: social, emotional, and physical health deficits and other persistent barriers to learning must be addressed if students are to learn effectively and schools are to accomplish their educational mission. It would be wonderful if the process of addressing such barriers could be handled solely by families or public and private community agencies. Unfortunately, these agencies are unable to do the job alone. Thus, if school reform is to be effective, schools must play a major role in easing problems, increasing opportunities, and enhancing the well-being of students and families.

Recognizing the crisis related to young people's well-being, the U.S. Department of Health and Human Services has launched a variety of initiatives aimed at enhancing the ability of schools to meet the needs of students and their families. One such effort focuses on mental health in schools. As part of this endeavor, two national training and technical assistance centers for mental health in schools were established in 1995 by the Health Resources and Services Administration, Bureau of Maternal and Child Health, Office of Adolescent Health: one center is at UCLA and the other at the University of Maryland at Baltimore.

It is clear that the success of any initiative focused on mental health in schools is dependent on the wide involvement and continuing education of all school personnel. Therefore, one of the major tasks of the UCLA School Mental Health Project's Center for Mental Health in Schools is development of continuing education materials for better mental health interventions in the context of moving toward a comprehensive, integrated approach to addressing barriers to student learning. A comprehensive, integrated approach encompasses (a) prevention and prereferral interventions for mild problems, (b) high visibility programs for high-frequency psychosocial problems, and (c) strategies to assist with severe and pervasive mental health problems. A comprehensive approach recognizes the role school, home, and community life play in creating and correcting young people's problems, especially those who are under-served and hard-to-reach.

We hope that the material contained in this document represents a timely and progressive approach. At the same time, the content, like the field itself, is seen as in a state of continuous evolution. Thus, we are extremely interested in receiving your feedback. Please send your comments to: Howard S. Adelman and Linda Taylor, Co-Directors, Center for Mental Health in Schools, UCLA, Department of Psychology, Los Angeles, CA 90095-1563.

Introduction

To Curriculum Designers Adopting this Material

The material in the continuing education module entitled *Addressing Barriers to Learning: New Directions for Mental Health in Schools* can be incorporated into various formats:

(1) self-study (individual or group)

(2) participation in workshops (a half or full day continuing education workshop; a sequence of district-wide inservice workshops)

(3) media and computer courses (instructional television -- live, and if feasible, interactive; video or audiotaped courses; computer courses, an internet offering)

(4) a professional journal offering a continuing education series.

The content is designed as an evolving set of modular units. Each unit consists of several sections conceived to stand alone. Thus, the total set can be used and taught in a straight forward sequence, or one or more units and sections can be combined into a personalized course. This design also allows learners to approach the material as they would use an internet website (i.e., exploring specific topics of immediate interest and then going over the rest in any order that feels comfortable). The units are packaged in a sequence that reflects the designers' preference for starting with a big picture framework for understanding the context and emerging directions for mental health in schools.

Beginning each section are specific objectives and focusing questions meant to help guide reading and review. Interspersed throughout each section are boxed material designed to help learners think in greater depth about the material. Test questions are provided at the end of each section as an additional study aid.

If the materials are used in a self-study format, instructors should encourage learners to survey and browse through the material and then read in greater depth. If feasible, learners should be encouraged to establish a study group. Such a group not only can help facilitate the learning of new ideas and skills, it lays a great foundation for ongoing networking, social support, and team building.

There is a set of *Accompanying Materials* that can provide learners with enrichment learning opportunities on key topics as well as with specific resource and technical aids to assist them in applying what they learn and to provide them and their colleagues at school sites with some specific tools.

Contents of the Instructor's Guide

- General and Expanded Outlines of Curriculum Content
- A Sample "Lesson Plan" for Offering the Curriculum in a Workshop Format
- Some Guidelines for Facilitating Small Groups in Workshops
- Activity and Materials for Follow-up Learning
- Surveys for Use in Follow-up Learning
- Test Questions and Answers

Continuing Education

Topic: *Addressing Barriers to Learning: New Directions for Mental Health in Schools*

Content:

I. Placing Mental Health into the Context of Schools and the 21st Century
- A. Introductory Overview
- B. The Need to Enhance Healthy Development and Address Barriers to Learning
- C. Addressing the Need: Moving Toward a Comprehensive Approach
- Coda: A Wide Range of Responses for a Wide Range of Problems

II. Mental Health Services & Instruction: What a School Can Do
- A. Screening and Assessment
- B. Problem Response and Prevention
- C. Consent, Due Process, and Confidentiality
- Coda: Networks of Care
- Follow-Up Reading
- •*ABCs of Assessment*
- •*Managing and Preventing School Misbehavior and School Avoidance*

III. Working with Others to Enhance Programs and Resources
- A. Working Relationships
- B. Working to Enhance Existing Programs
- C. Building a Comprehensive, Integrated Approach at Your School
- Coda: New Roles for Schools: A Multifaceted Focus

Glossary of Key Terms, Acronyms, and Laws

Accompanying Resource and Technical Aids:

Parent and Home Involvement in Schools
Screening/Assessment: Indicators and Tools
Substance Abuse: Indicators and Screening
School-Based Client Consultation, Referral, and Management of Care
Responding to Crisis in Schools
Where to Get Resource Materials
Students and Psychotropic Medication: The School's Role

Expanded Content Outlines:

I. Placing Mental Health into the Context of Schools and the 21st Century
- A. Introductory Overview
  - State of the Art
  - *Emerging Trends*
  - New Roles
- B. The Need to Enhance Healthy Development and Address Barriers to Learning
  - Promoting Healthy Development
  - Personal and Systemic Barriers to Student Learning
  - Family Needs for Social and Emotional Support
  - Staff Needs for Social and Emotional Support
- C. Addressing the Need: Moving Toward a Comprehensive Approach
  - Meeting Mandates: Necessary . . . but Insufficient and Often Unsatisfying
  - Understanding What Causes Different Types of Problems
  - Clinical Approaches at School Sites
  - School-Based Health Centers, Family Service Centers, and Full Service Schools
  - Programmatic Approaches: Going Beyond Clinical Interventions to Address the Full Range of Problems
  - Needed: A Full Continuum of Programs and Services
- Coda: A Wide Range of Responses for a Wide Range of Problems

II. Mental Health Services & Instruction: What a School Can Do
- A. Screening and Assessment
  - Initial Problem Identification
  - Connecting a Student with the Right Help
    - Screening to Clarify Need
    - Client Consultation and Referral
    - Triage
    - Initial Case Monitoring
- B. Problem Response and Prevention
  - Psychological First Aid: Responding to a Student in Crisis
  - Primary Prevention and Treatment
    - Mental Health Education
    - Psychosocial Guidance and Support
    - Psychosocial Counseling
  - Ongoing Case Monitoring
  - To Review
- C. Consent, Due Process, and Confidentiality
- Coda: Networks of Care
- Follow-Up Reading
- *•ABCs of Assessment*
- *•Managing and Preventing School Misbehavior and School Avoidance*

III. Working with Others to Enhance Programs and Resources
- A. Working Relationships
  - Differences as a Problem
  - Differences as a Barrier
  - Overcoming Barriers Related to Differences
  - Building Rapport and Connection
  - One Other Observation
- B. Working to Enhance Existing Programs
  - It's Not About Collaboration. It's About Being Effective
  - A Team to Manage Care
  - A Team to Manage Resources
- C. Building a Comprehensive, Integrated Approach at Your School
  - Classroom-Focused Enabling
  - Crisis Assistance and Prevention
  - Support for Transitions
  - Student and Family Assistance
  - Home Involvement in Schooling
  - Community Outreach for Involvement and Support (including a focus on volunteers)

Coda: New Roles for Schools: A Multifaceted Focus

Sample "Lesson Plan" for Offering the Curriculum in a Workshop Format

Topic: *Addressing Barriers to Learning: New Directions for Mental Health in Schools*

Unit II: Mental Health Services & Instruction: What a School Can Do

I. Assignment to Prepare Participants for a Session

Prior to the workshop, do any of the following activities -- with a view to sharing a bit of what you learned from the experience with others at the workshop.

1. In journal form, briefly describe a student who you are having difficulty helping -- note a few things you have tried to do and why you think they haven't worked.

2. Reflect on and write-up a brief description of your efforts to help students who come to you about psychosocial and mental health concerns. If you can, write this in terms of how you think the students experience it.

3. Read something recent about school reform and decide what changes, if any, you would want to make in your school to improve the way it addresses students' problems.

4. In journal form, briefly reflect on what you were like when you were the age of your students. Think of both a positive and negative incident and of something you needed from the school that you got and something that you didn't get.

5. Any other activity you would like to do and share at the session.

II. Warm-up Activity

Small Group Sharing of What Participants Learned from the Presession Assignment (20 minutes).

Create and guide small groups to share and discuss -- briefly -- the presession activity that each member chose.

(A set of "Group Guidelines" is attached for use as is or for adaptation.)

III. Introduction to the Unit

Overview of what the unit covers (10 minutes)

Mental Health Services & Instruction: What a School Can Do

Points for emphasis:

The unit will cover

•identifying and processing students in need of assistance
for mental health and psychosocial problems
>initial problem identification
>connecting a student with the right help
screening to clarify need
client consultation and referral
triage
initial case monitoring

•problem response and prevention
>psychological first aid: responding to a student in crisis
>primary prevention and treatment
mental health education
psychosocial guidance and support
psychosocial counseling
>ongoing case monitoring

•consent, due process, and confidentiality

IV. Topic Exploration

A. *Identifying and Processing Students who Need Assistance*

1. Brainstorming in small groups (15 minutes)

What role and functions can a school play in identifying and screening mental health and psychosocial problems?

(See the set of "Group Guidelines" included in this guide and use as is or adapt.)

2. Presentation (35-40 minutes)

(See the unit's text and choose points to highlight.)

The intent of the presentation is to enhance knowledge and skills about

a. Initial identification of mental health and psychosocial problems.

b. Connecting a student with the right help

•screening/assessment
•client consultation and referral
•triage
•initial case monitoring

B. *Psychosocial Helping Intervention*

1. Brainstorming in small groups (15 minutes)

   Think about the last school crisis event. What was done to deal with students experiencing immediate and subsequent psychological trauma?

   (Again refer to the "Group Guidelines.")

2. Two Presentations (35-40 minutes each)

   (See the unit's text and choose points to highlight.)

   The intent of the presentations are to enhance knowledge and skills about

   a. Psychological first aid.

   b. Mental health education

   c. Psychosocial guidance and support

   d. Psychosocial counseling

   e. Ongoing case monitoring

   f. Consent and confidentiality

Provide follow-up packet -- copies of the written version of the content covered, other follow-up readings, and related resource and technical aids.

V. Explanation of Assignments for Follow-up of this Session (5 minutes)

(See section in Instructor's Guide on *Activity and Materials for Follow-up Learning*)

Some Guidelines for Facilitating Small Groups in Workshops

(The following guidelines can be adapted and copied for use as a handout.)

Sharing and Discussion of the Activity You Pursued in Preparing for this Session

Group Guidelines

(1) Form small groups to briefly and informally share and discuss the presession activity that each member chose. The objective is simply to set the tone for what will be explored as part of this unit.

(2) Someone in the group should volunteer to facilitate an "on task" focus.

(3) Someone else in the group should volunteer to be time keeper. There is only 20 minutes for this activity.

(4) Start with volunteers. As a first round, each member should just share a bit of what they learned from her/his chosen activity.

(5) If there is time after each person has shared, begin a discussion of what you see as the major barriers experienced in the classroom that interfere with students' learning.

(The following guidelines can be adapted and copied for use as a handout.)

Brainstorming: What role and functions can a school play in identifying and screening mental health and psychosocial problems?

Group Guidelines

(1) You have 15 minutes for this activity.

(2) Form small groups.

(3) Someone in the group should volunteer to facilitate an "on task" focus.

(4) Someone else should volunteer to "chart" the ideas.

(5) Begin brainstorming -- remember not to criticize any contribution.

(6) If there is time categorize the ideas and rank them according to which seem like the most promising.

Activity and Materials for Follow-up Learning

(The following description can be adapted and copied use as a handout.)

FOLLOW-UP ACTIVITY

Self-learning

- The attached packet contains reading and related material that can facilitate your efforts to learn more on your own about the topics covered in the session you just completed.
- Ask for additional resources from:

Work with others

- Reach out for support/mentoring/coaching from:
- Participate with others in clusters and teams
- Request additional staff development on these topics

In your *follow-up packet*, you will find the following:

- A Written Version of the Material Covered
- A set of resource and technical aids that you and your school colleagues can draw on for additional materials covering:

  Parent and Home Involvement in Schools
  Screening/Assessment: Indicators and Tools
  Substance Abuse: Indicators and Screening
  School-Based Client Consultation, Referral, and Management of Care
  Responding to Crisis in Schools
  Where to Get Resource Materials
  Students and Psychotropic Medication: The School's Role

- Some Enrichment Readings:

  ABCs of Assessment
  Managing and Preventing School Misbehavior and School Avoidance

- A Self-Study Tool

  A survey instrument for use in examining your setting with a view to enhancing your school's system for dealing with mental health and psychosocial concerns.

Surveying and Planning to Enhance a Schools Efforts to Address Mental Health and Psychosocial Concern

Attached are 2 surveys from a set of seven developed by the School Mental Health Project/Center for Mental Health in Schools. The total set are designed to aid school staff as they try to map and analyze their current programs, services, and systems.*

The 2 surveys included here specifically focus on:

Survey of System Status -- to clarify the current situation at a school site with respect to leadership, planning and implementation teams, processes for referral, triage, case management, and so forth

Student and Family Assistance Program Status -- to clarify the current situation with respect to specific programs and the processes used to build capacity.

*The other 5 Surveys (available from the UCLA Center for Mental Health in Schools are:

- **classroom-based efforts** to enhance learning and performance of students with mild-moderate learning, behavior, and emotional problems
- support for **transitions**
- **crisis assistance and prevention**
- **home involvement in schooling**
- outreaching to develop greater **community involvement** and support -- including recruitment of volunteers

Survey of System Status

As your school sets out to enhance the usefulness of education support programs designed to address barriers to learning, it helps to clarify what you have in place as a basis for determining what needs to be done. You will want to pay special attention to

- *clarifying what resources already are available*
- *how the resources are organized to work in a coordinated way*
- *what procedures are in place for enhancing resource usefulness*

This survey provides a starting point.

Items 1-6 ask about what processes are in place.
Use the following ratings in responding to these items.

DK = don't know
1 = not yet
2 = planned
3 = just recently initiated
4 = has been functional for a while
5 = well institutionalized (well established with a commitment to maintenance)

Items 7-10 ask about effectiveness of existing processes.
Use the following ratings in responding to these items.

DK = don't know
1 = hardly ever effective
2 = effective about 25% of the time
3 = effective about half the time
4 = effective about 75% of the time
5 = almost always effective

DK = don't know
1 = not yet
2 = planned
3 = just recently initiated
4 = has been functional for a while
5 = well institutionalized

1. Is someone at the school designated as **coordinator/leader** for activity designed to address barriers to learning (e.g., education support programs, health and social services, the Enabling Component)? DK 1 2 3 4 5

2. Is there a time and place when **personnel** involved in activity designed to address barriers to learning **meet** together? DK 1 2 3 4 5

3. Do you have a **Resource Coordinating Team**? DK 1 2 3 4 5

4. Do you have **written descriptions** available to give staff (and parents when applicable) regarding

   (a) **activities** available **at the site** designed to address barriers to learning (programs, teams, resources, services -- including parent and family service centers if you have them)? DK 1 2 3 4 5

   (b) **resources** available **in the community**? DK 1 2 3 4 5

   (c) a **system** for staff to use in making **referrals**? DK 1 2 3 4 5

   (d) a **system** for **triage** (to decide how to respond when a referral is made)? DK 1 2 3 4 5

   (e) a **case management** system? DK 1 2 3 4 5

   (f) a **student study team**? DK 1 2 3 4 5

   (g) a **crisis team**? DK 1 2 3 4 5

   (h) Specify below any other relevant programs/services -- including preventive approaches (e.g., prereferral interventions; welcoming, social support, and articulation programs to address transitions; programs to enhance home involvement in schooling; community outreach and use of volunteers)?

   _____ DK 1 2 3 4 5
   _____ DK 1 2 3 4 5
   _____ DK 1 2 3 4 5
   _____ DK 1 2 3 4 5

5. Are there effective **processes by which staff and families learn**

   (a) **what is available** in the way of programs/services? DK 1 2 3 4 5

   (b) **how to access** programs/services they need? DK 1 2 3 4 5

6. With respect to your **complex/cluster's** activity designed to address barriers to learning has someone at the school been designated as a **representative** to meet with the other schools? DK 1 2 3 4 5

BEST COPY AVAILABLE

DK = don't know
1 = hardly ever effective
2 = effective about 25% of time
3 = effective about half of time
4 = effective about 75% of time
5 = almost always effective

7. How **effective** is the

(a) referral system?	DK	1	2	3	4	5
(b) triage system?	DK	1	2	3	4	5
(c) case management system?	DK	1	2	3	4	5
(d) student study team?	DK	1	2	3	4	5
(e) crisis team?	DK	1	2	3	4	5

8. How **effective** are the **processes** for

(a) planning, implementing, and evaluating **system improvements** (e.g., related to referral, triage, case management, student study team, crisis team, prevention programs)?	DK	1	2	3	4	5
(b) **enhancing resources** for assisting students and family (e.g., through staff development; developing or bringing new programs/services to the site; making formal linkages with programs/services in the community)?	DK	1	2	3	4	5

9. How **effective** are the **processes** for ensuring that

(a) **resources** are properly **allocated and coordinated**?	DK	1	2	3	4	5
(b) **linked community services are effectively coordinated/ integrated with related activities at the site?**	DK	1	2	3	4	5

10. How **effective** are the **processes** for ensuring that **resources** available to the whole complex/cluster are properly **allocated and shared/coordinated**?

	DK	1	2	3	4	5

Please list **community resources** with which you have formal relationships.

(a) Those that bring program(s) to the school site

(b) Those not at the school site but which have made a special commitment to respond to the school's referrals and needs.

BEST COPY AVAILABLE

Student and Family Assistance Programs and Services: Survey of Program Status

The emphasis here is on providing special services in a personalized way to assist with a broad-range of needs. To begin with, available social, physical and mental health programs in the school and community are used. As community outreach brings in other resources, they are linked to existing activity in an integrated manner. Special attention is paid to enhancing systems for triage, case and resource management, direct services to meet immediate needs, and referral for special services and special education resources and placements as appropriate. Intended outcomes are to ensure special assistance is provided when necessary and appropriate and that such assistance is effective.

Please indicate all items that apply.

		Yes	Yes but more of this is needed	No	If no, is this something you want?
A.	Are there classroom focused enabling programs to reduce the need for teachers to seek special programs and services?	___	___	___	___
B.	What activity is there to facilitate and evaluate requests for assistance?				
	1. Does the site have a directory that lists services and programs?	___	___	___	___
	2. Is information circulated about services/programs?	___	___	___	___
	3. Is information circulated clarifying how to make a referral?	___	___	___	___
	4. Is information about services, programs, and referral procedures updated periodically?	___	___	___	___
	5. Is a triage process used to assess				
	a. specific needs?	___	___	___	___
	b. priority for service?	___	___	___	___
	6. Are procedures in place to ensure use of prereferral interventions?	___	___	___	___
	7. Do inservice programs focus on teaching the staff ways to prevent unnecessary referrals?	___	___	___	___
	8. Other? (specify) _____	___	___	___	___
C.	After triage, how are referrals handled?				
	1. Is detailed information provided about available services (e.g., is an annotated community resource system available)?	___	___	___	___
	2. Is there a special focus on facilitating effective decision making?	___	___	___	___
	3. Are students/families helped to take the necessary steps to connect with a service or program to which they have been referred?	___	___	___	___
	4. Other? (specify) _____	___	___	___	___

BEST COPY AVAILABLE

D. What types of direct interventions are provided currently?	Yes	Yes but more of this is needed	No	If no, is this somethi you wan
1. Which **medical** services and programs are provided?				
a. immunizations	___	___	___	___
b. first aid and emergency care	___	___	___	___
c. crisis follow-up medical care	___	___	___	___
d. health and safety education and counseling	___	___	___	___
e. screening for vision problems	___	___	___	___
f. screening for hearing problems	___	___	___	___
g. screening for health problems (specify)_____	___	___	___	___
h. screening for dental problems (specify)_____	___	___	___	___
i. treatment of some acute problems (specify)_____	___	___	___	___
j. other (specify) _____	___	___	___	___
2. Which **psychological** services and programs are provided?				
a. psychological first aid	___	___	___	___
b. crisis follow-up counseling	___	___	___	___
c. crisis hotlines	___	___	___	___
d. conflict mediation	___	___	___	___
e. alcohol and other drug abuse programs	___	___	___	___
f. pregnancy prevention program	___	___	___	___
g. gang prevention program	___	___	___	___
h. dropout prevention program	___	___	___	___
i. physical and sexual abuse prevention	___	___	___	___
j. individual counseling	___	___	___	___
k. group counseling	___	___	___	___
l. family counseling	___	___	___	___
m. mental health education	___	___	___	___
n. home outreach	___	___	___	___
o. other (specify) _____	___	___	___	___
3. Which of the following are provided to meet **basic survival needs**?				
a. emergency food	___	___	___	___
b. emergency clothing	___	___	___	___
c. emergency housing	___	___	___	___
d. transportation support	___	___	___	___
e. welfare services	___	___	___	___
f. language translation	___	___	___	___
g. legal aid	___	___	___	___
h. protection from physical abuse	___	___	___	___
i. protection from sexual abuse	___	___	___	___
j. employment assistance	___	___	___	___
k. other (specify) _____	___	___	___	___

BEST COPY AVAILABLE

	Yes	Yes but more of this is needed	No	If no, is this somethir you wan
4. Which of the following **special education, Special Eligibility, and independent study** programs and services are provided?				
a. early education program	___	___	___	___
b. special day classes (specify)_____	___	___	___	___
c. speech and language therapy	___	___	___	___
d. adaptive P.E.	___	___	___	___
e. special assessment	___	___	___	___
f. Resource Specialist Program	___	___	___	___
g. Chapter 1	___	___	___	___
h. School Readiness Language Develop. Program (SRLDP)	___	___	___	___
i. other (specify) _____	___	___	___	___
5. Which of the following **adult education** programs are provided?				
a. ESL				
b. citizenship classes	___	___	___	___
c. basic literacy skills	___	___	___	___
d. parenting	___	___	___	___
e. helping children do better at school	___	___	___	___
f. other (specify) _____	___	___	___	___
6. Are services and programs provided to enhance **school readiness**? specify _____	___	___	___	___
7. Which of the following are provided to address **attendance problems**?				
a. absence follow-up	___	___	___	___
b. attendance monitoring	___	___	___	___
c. first day calls	___	___	___	___
8. Are **discipline proceedings** carried out regularly?	___	___	___	___
9. Other? (specify) _____	___	___	___	___
E. Which of the following are used to manage cases and resources?				
1. Is a student information system used?	___	___	___	___
2. Is a system used to trail progress of students and their families?	___	___	___	___
3. Is a system used to facilitate communication for				
a. case management?	___	___	___	___
b. resource and system management?	___	___	___	___
4. Are there follow-up systems to determine				
a. referral follow-through?	___	___	___	___
b. consumer satisfaction with referrals?	___	___	___	___
c. the need for more help?	___	___	___	___
5. Other? (specify) _____	___	___	___	___

BEST COPY AVAILABLE

	Yes	Yes but more of this is needed	No	If no, is this somethin you wan
F. Which of the following are used to help enhance the quality and quantity of services and programs?				
1. Is a quality improvement system used?	___	___	___	___
2. Is a mechanism used to coordinate and integrate services/programs?	___	___	___	___
3. Is there outreach to link-up with community services and programs?	___	___	___	___
4. Is a mechanism used to redesign current activity as new collaborations are developed?	___	___	___	___
5. Other? (specify) _____	___	___	___	___
G. What programs are used to meet the educational needs of personnel related to this programmatic area?				
1. Is there ongoing training for team members concerned with the area of Student and Family Assistance?	___	___	___	___
2. Is there ongoing training for staff of specific services/programs (e.g., Assessment and Consultation Team, direct service providers)	___	___	___	___
3. Other? (specify) _____	___	___	___	___
H. Which of the following topics are covered in educating stakeholders?				
1. broadening understanding of causes of learning, behavior, and emotional problems	___	___	___	___
2. broadening understanding of ways to ameliorate (prevent, correct) learning, behavior, and emotional problems	___	___	___	___
3. developing systematic academic supports for students in need	___	___	___	___
4. what classroom teachers and the home can do to minimize the need for special interventions	___	___	___	___
5. enhancing resource quality, availability, and scope	___	___	___	___
6. enhancing the referral system and ensuring effective follow-through	___	___	___	___
7. enhancing the case management system in ways that increase service efficacy	___	___	___	___
8. other (specify) _____	___	___	___	___

BEST COPY AVAILABLE

I. Please indicate below any other ways that are used to provide student and family assistance to address barriers to students' learning.

J. Please indicate below other things you want the school to do to provide student and family assistance to address barriers to students' learning.

BEST COPY AVAILABLE

ADDRESSING BARRIERS TO LEARNING: NEW DIRECTIONS FOR MENTAL HEALTH IN SCHOOLS

Test Questions and Answers

Questions

Unit I: Section A

(1) Which of the following were identified as potential interveners who could play a role could play a role in counseling, psychological, and social service activity at a school?

____(a) counselors
____(b) nurses
____(c) teachers
____(d) aides
____(e) students
____(f) a & b
____(g) a, b, & e
____(h) all the above

(2) With respect to the activities carried out by such interveners, enumerate two specific functions related to

(a) providing direct services and instruction

_____

_____

(b) coordinating, developing, and providing leadership for programs, services, and systems

_____

_____

(c) enhancing connections with community resources

_____

_____

(3) Which of the following is ***not*** an emerging trend related to health and psychosocial programs in schools?

___(a) the move *from* narrowly focused *to* comprehensive approaches

___(b) the move *from* fragmentation *to* coordinated/integrated intervention

___(c) the move *from* problem specific and discipline-oriented services *to* less categorical, cross-disciplinary programs

___(d) the move *from* viewing health programs as "supplementary services" *to* policy changes that recognize physical and mental health services as an essential element in enabling learning

___(e) all are emerging trends

(4) Enumerate three possible new roles that schools might play in addressing mental health and psychosocial concerns in schools.

_____

_____

_____

Unit I: Section B

(1) Which of the following can be barriers to student learning?

___(a) deficiencies in basic living resources
___(b) psychosocial problems
___(c) underlying psychological problems
___(d) family crises
___(e) transitions such as moving to a new school
___(f) all of the above

(2) Health and social services are designed to address the full range of factors that cause poor academic performance, dropouts, gang violence, teen pregnancy, substance abuse, and so forth.

____True ____False

(3) List five major areas of focus in enhancing healthy psychosocial development.

_____

_____

_____

_____

_____

(4) Current diagnostic systems such as the *Diagnostic and Statistical Manual of Mental Disorders -- DSM IV* do not adequately account for psychosocial problems>

____True ____False

(5) Formal systems for classifying problems in human functioning convey the impression that all behavioral, emotional, or learning problems are due to internal pathology.

____True ____False

(6) Most differential diagnoses of children's problems are made by focusing on identifying one of more internal disorders rather than first asking "Is there a disorder?".

____True ____False

(7) Attributional bias is a tendency for observers to perceive others' problems as rooted in stable personal dispositions.

____True ____False

(8) In the mental health field, the tendency is to see most student's problems as arising from environmental/social factors.

____True ____False

(9) List three characteristics of family-oriented interventions.

Unit I: Section C

(1) Which of the following are implications of understanding a student's problems in terms of a causal continuum that ranges from internal to external causes?

___(a) some problems primarily result from biological or psychological factors
___(b) some problems primarily result from environmental causes
___(c) some problems are caused by the environment not accommodating individual differences and vulnerabilities
___(d) a and b
___(e) all of the above
___(f) none of the above

(2) Improving the way the environment accommodates individual differences may be a sufficient intervention strategy.

_____True _____False

(3) School-Based Health Centers have come to find it necessary to address mental health and psychosocial concerns because

___(a) mental health is more important than physical health
___(b) many students physical complaints are psychogenic
___(c) mental health services are less costly
___(d) many students come to the centers for help with psychosocial problems
___(e) a and b
___(f) a and c
___(g) b and d
___(h) all of the above

(4) With respect to addressing barriers to learning, a comprehensive approach requires more than a focus on health and social services.

_____True _____False

(5) A comprehensive approach to addressing barriers to learning is achieved by outreaching to link with community resources.

_____True _____False

(6) With respect to addressing barriers to learning, a comprehensive approach requires more than coordination of school and community services.

_____True _____False

(7) Moving toward comprehensiveness in addressing barriers to learning encompasses restructuring, transforming, and enhancing (a) relevant school-owned programs and services, (b) community resources, and (c) weaving these school and community resources together.

_____True _____False

Unit II: Section A

(1) Which of the following were discussed as major facets of identifying and processing students in need of assistance for mental health and psychosocial problems?

___(a) initial problem identification
___(b) screening/assessment
___(c) client consultation and referral
___(d) triage
___(e) initial case monitoring
___(f) a, b, d
___(g) a, b, e
___(h) all the above

(2) It is especially hard to know the underlying cause of a problem when a student is not very motivated to learn and perform at school

___True ___False

(3) Screening can be used to help clarify the nature, extent, and severity of a problem?

___True ___False

(4) The instrument for screening suicidal risk doesn't ask about

___(a) past attempts, current plans, and view of death
___(b) reactions to precipitating events
___(c) available psychosocial support
___(d) attitudes toward school
___(e) history of risk-taking behavior

(5) Which of the following are a focus of the initial interview/questionnaire instruments

___(a) the student's perception of the problem
___(b) what has been tried previously to deal with the problem
___(c) motivation to do something about the problem
___(d) a, b
___(e) all the above

Unit II: Section B

(1) The immediate objective of psychological first-aid is to

___(a) eliminate the fear individuals experience during and in the immediate aftermath of a crisis
___(b) help individuals deal with troubling psychological reactions during and in the immediate aftermath of a crisis
___(c) tell students counseling will be made available to them
___(d) all of the above

(2) Three phases of crisis intervention are (a) managing the situation, (b) mobilizing support, and (c) following-up.

___True ___False

(3) The following list mixes together general activities related to providing psychosocial guidance and support with specific things that can be done to facilitate student communication in a psychosocial counseling situation.

Put a + before the items that describe general activities related to providing psychosocial guidance and support.

___(a) advising
___(b) providing advocacy and protection
___(c) responding with empathy, warmth, nurturance, and positive regard
___(d) providing support for transitions
___(e) listening with interest
___(f) creating a private space and a climate where the student can feel it is safe to talk
___(g) clarifying the role and value of keeping things confidential
___(h) encouraging the student to take the lead
___(i) providing mediation and conflict resolution
___(j) promoting and fostering opportunities for social and emotional development
___(k) being a liaison between school and home
___(l) being a liaison between school and other professionals serving a student

Unit II: Section C

(1) Which of the following are major aspects of the legal concept of consent?

___(a) a person must have the capacity to consent
___(b) a person must have appropriate and sufficient information before being asked to consent
___(c) a person's consent must be given voluntarily
___(d) a and b
___(e) a and c
___(f) b and c
___(d) all of the above

(2) It is important to maintain a client's confidentiality to protect embarrassing information from disclosure.

___True ___False

(3) It is important to maintain a client's confidentiality to minimize the likelihood of discrimination against the person.

___True ___False

(4) It is important to be able to offer confidentiality to encourage individuals to use services.

___True ___False

(5) Identify two major exceptions to client confidentiality in a psychosocial counseling situation.

_____ _____

Unit III: Section A

(1) Of the various necessary ingredients in building positive working relationships, list three of those covered in this unit.

_____

_____

_____

(2) Enumerate three of the five cultural competence values as defined by Mason, Benjamin, & Lewis (1996).

_____

_____

_____

(3) There is a danger inherent in making prejudgments based on apparent cultural awareness.

True ____ False____

(4) Poor working relationships arise whenever there are individual, racial, or cultural differences.

True ____ False____

(5) Which of the following are things to do to help build working relationships and effective communication?

____ (a) convey empathy and warmth

____ (b) convey genuine regard and respect

____ (c) talk with, not at, others

____ (d) a & b

____ (e) all the above

Unit III: Section B

(1) Enumerate two of the basis tasks for primary managers of care as discussed in this unit.

_____

_____

(2) Enumerate two of the major functions of a school-based team designed to manage resources as discussed in this unit.

_____

_____

(3) Parents can be part of a management of care team.

True ____ False____

(4) Perhaps the most valuable aspect of mapping and analyzing a school's resources for addressing barriers to learning and promoting healthy development is that the products provide a sound basis for improving cost-effectiveness.

True ____ False____

(5) A school-based Resource Coordinating Team has the same functions as a team created to review individual students.

True ____ False____

Unit III: Section C

(1) Indicate three primary and essential components discussed in this unit that need to be addressed in reform efforts by schools/communities.

_____

_____

_____

(2) Enumerate six program areas of an Enabling Component.

_____

_____

_____

_____

_____

_____

(3) The concepts of (a) an Enabling Component and (b) School linked services are different terms for the same approach to addressing barriers to learning and enhancing healthy development.

True ____ False____

(4) School-owned enabling activity -- such as pupil services and the multi-components of a school health program -- must be coordinated and integrated not only with each other but with community-owned resources.

True ____ False____

Answers

Unit I: Section A

(1) h

(2) Two from each of the following three categories:

Direct services and instruction

- Identifying and processing students in need of assistance (e.g., initial screening, gatekeeping and triage, client consultation, referral, initial monitoring of care)
- Indepth assessment (individuals, groups, classroom, school, and home environments)
- Crisis intervention and emergency assistance (e.g., psychological first-aid and follow-up; suicide prevention; emergency services, such as food, clothing, transportation)
- Primary prevention through protection, mediation, promoting and fostering opportunities, positive development, and wellness (e.g., guidance counseling; contributing to development and implementation of health and violence reduction curricula; placement assistance; advocacy; liaison between school and home; gang, delinquency, and safe-school programs; conflict resolution)
- Transition and follow-up (e.g., orientations, social support for newcomers, follow-thru)
- Treatment/therapy/counseling, remediation, rehabilitation (incl. secondary prevention)
- Increasing the amount of direct service impact through ongoing management of care multidisciplinary teamwork, consultation, training, and supervision

Coordination, development, and leadership for programs, services, resources, systems

- Needs assessment
- Coordinating activities (e.g., participating on resource coordinating teams to enhance coordination across disciplines and components; with regular, special, and compensatory educ.; in and out of school)
- Mapping and enhancing resources and systems
- Developing new approaches (incl. facilitating systemic changes)
- Monitoring and evaluating intervention for quality improvement, cost-benefit accountability, research
- Advocacy for programs and services and for standards of care in the schools
- Pursuing strategies for public relations and for enhancing financial resources

Enhancing connections with community resources

- Strategies to increase responsiveness to referrals from the school
- Strategies to create formal linkages among programs and services

(3) e

(4) Any of the following:

- providing direct services and instruction related to mental health and psychosocial concerns
- consulting with teachers and others at the school regarding how to better address mental health and psychosocial concerns
- advocating for school-based programs and services to address mental health and psychosocial concerns
- facilitating system reforms to ensure that mental health and psychosocial concerns are addressed
- coordinating resource integration related to mental health and psychosocial concerns
- outreaching to increase collaboration with relevant community resources

Unit I: Section B

(1) f
(2) False
(3) Five of the following:

- Responsibility and integrity
- Self-esteem
- Social and working relationships
- Self-evaluation/self-direction/self-regulation
- Temperament
- Personal safety and safe behavior
- Health maintenance
- Effective physical functioning
- Careers and life roles
- Creativity

(Credit may be given if a specific example of any category given in text is listed.)
(4) True
(5) True
(6) True
(7) True
(8) False
(9) Three of the following:

- Enhancing a sense of community
- Mobilizing resources and supports
- Shared responsibility and collaboration
- Protecting family integrity
- Strengthening family functioning
- Proactive human service practices

Unit I: Section C

(1) e
(2) True
(3) g
(4) True
(5) False
(6) True
(7) True

Unit II: Section A

(1) h
(2) True
(3) True
(4) d
(5) e

Unit II: Section B

(1) b
(2) True
(3) + for items a, b, d, i, j, k, l

Unit II: Section C

(1) d
(2) True
(3) True
(4) True
(5) Two of the following
- student is being abused
- student has a plan to seriously hurt someone else
- student has a plan to seriously hurt self

Unit III: Section A

(1) Three of the following:
- minimizing negative prejudgments about those with whom you will be working
- taking time to make connections
- identifying what will be gained from the collaboration in terms of mutually desired outcomes -- to clarify the value of working together
- enhancing expectations that the working relationship will be productive -- important here is establishing credibility with each other
- establishing a structure that provides support and guidance to aid task focus
- periodic reminders of the positive outcomes that have resulted from working together

(2) Three of the following:
- Valuing Diversity
- Conducting Cultural Self-Assessment
- Understanding the Dynamics of Difference
- Incorporating Cultural Knowledge
- Adapting to Diversity

(3) True
(4) False
(5) e

Unit III: Section B

(1) Two of the following:
- write up analyses of monitoring findings and recommendations to share with management team;
- immediately after a team meeting, write up and circulate changes proposed by management team and emphasize who has agreed to do which tasks by when.
- set-up a "tickler" system to remind you when to check on whether tasks have been accomplished;
- follow-up with team members who have not accomplished agreed upon tasks to see what assistance they need.

(2) Two of the following:
- assessing needs
- mapping resources
- coordinating resources
- analyzing resources
- enhancing resources

(3) True
(4) True
(5) False

Unit III: Section C

(1) The 3 components are:
- Instructional Component
- Enabling Component
- Management Component

(2) The six program areas are:
- Classroom-Focused Enabling
- Student and Family Assistance
- Crisis Assistance and Prevention
- Support for Transitions
- Home Involvement in Schooling
- Community Outreach for Involvement and Support

(3) False
(4) True